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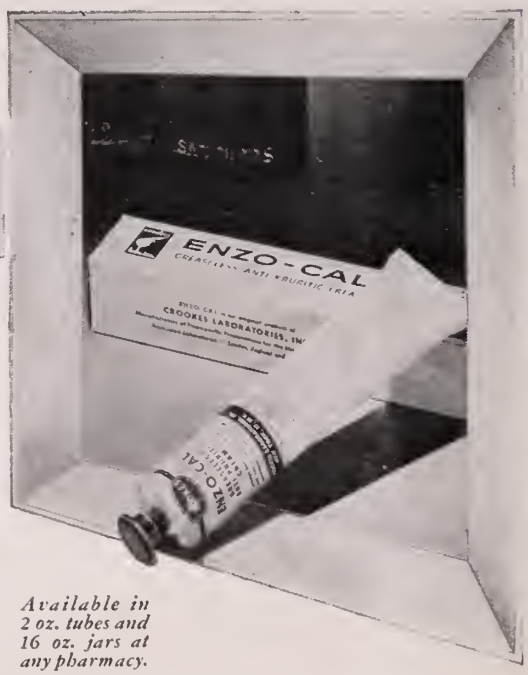
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Volume XXIX, 1946

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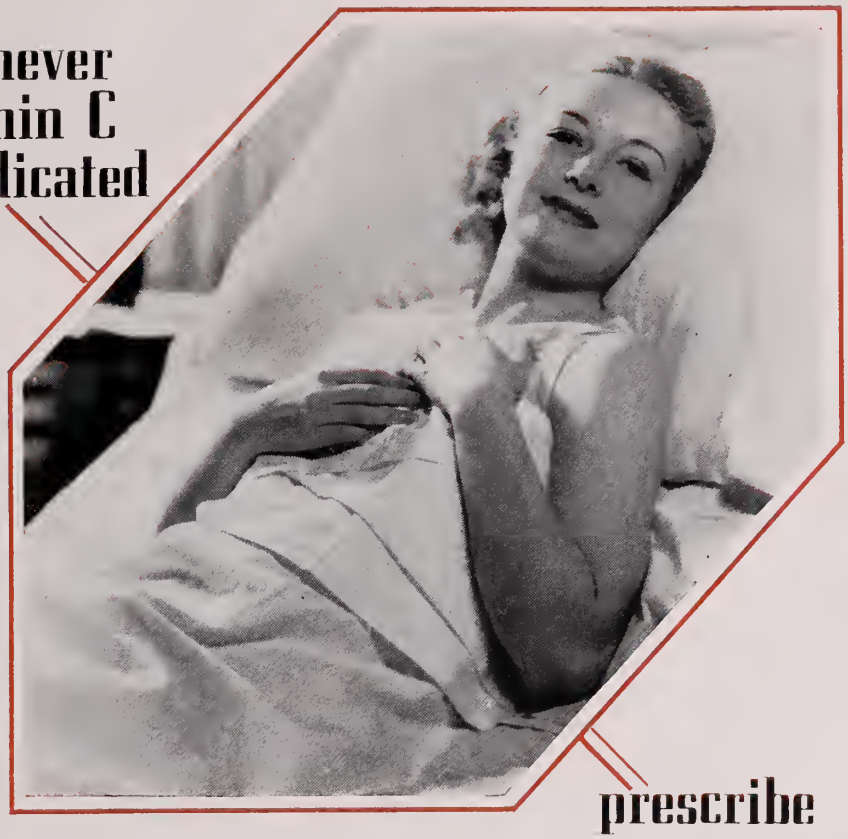
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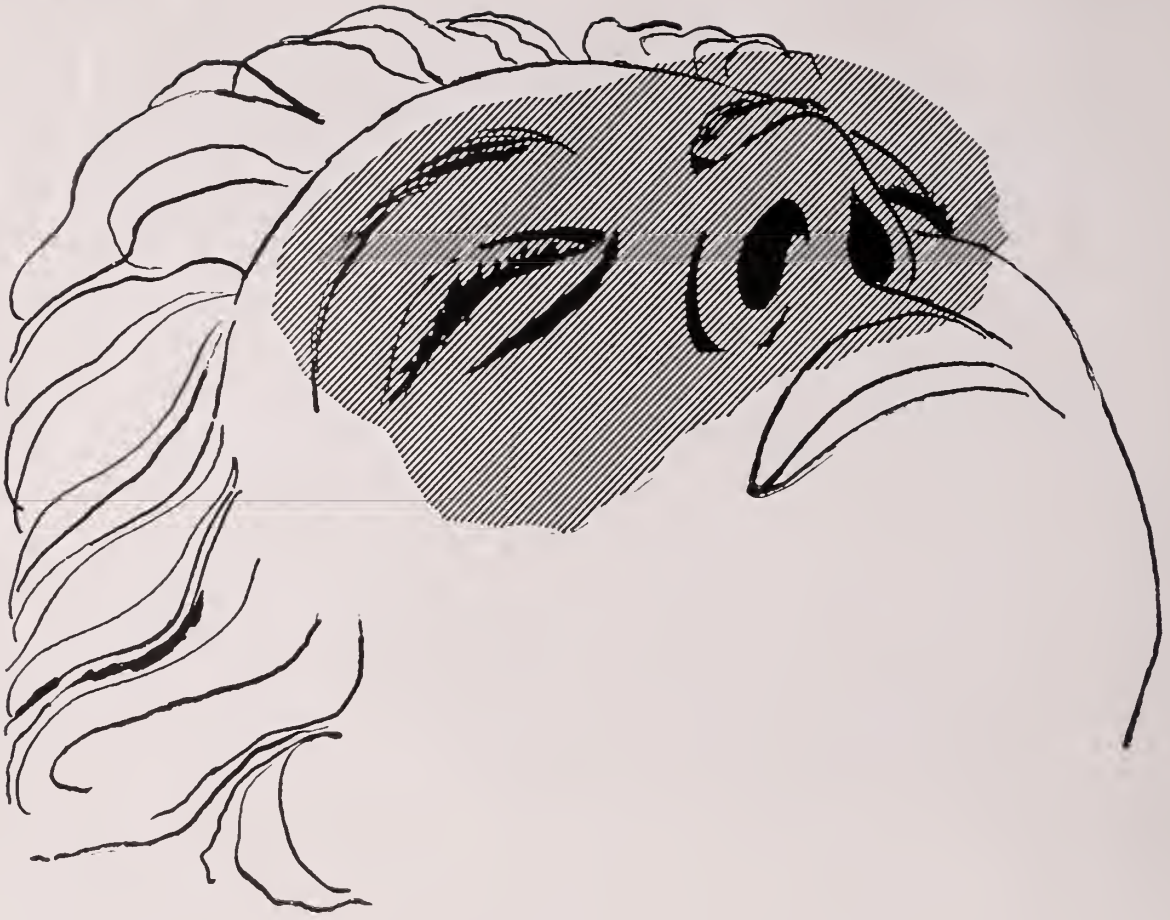
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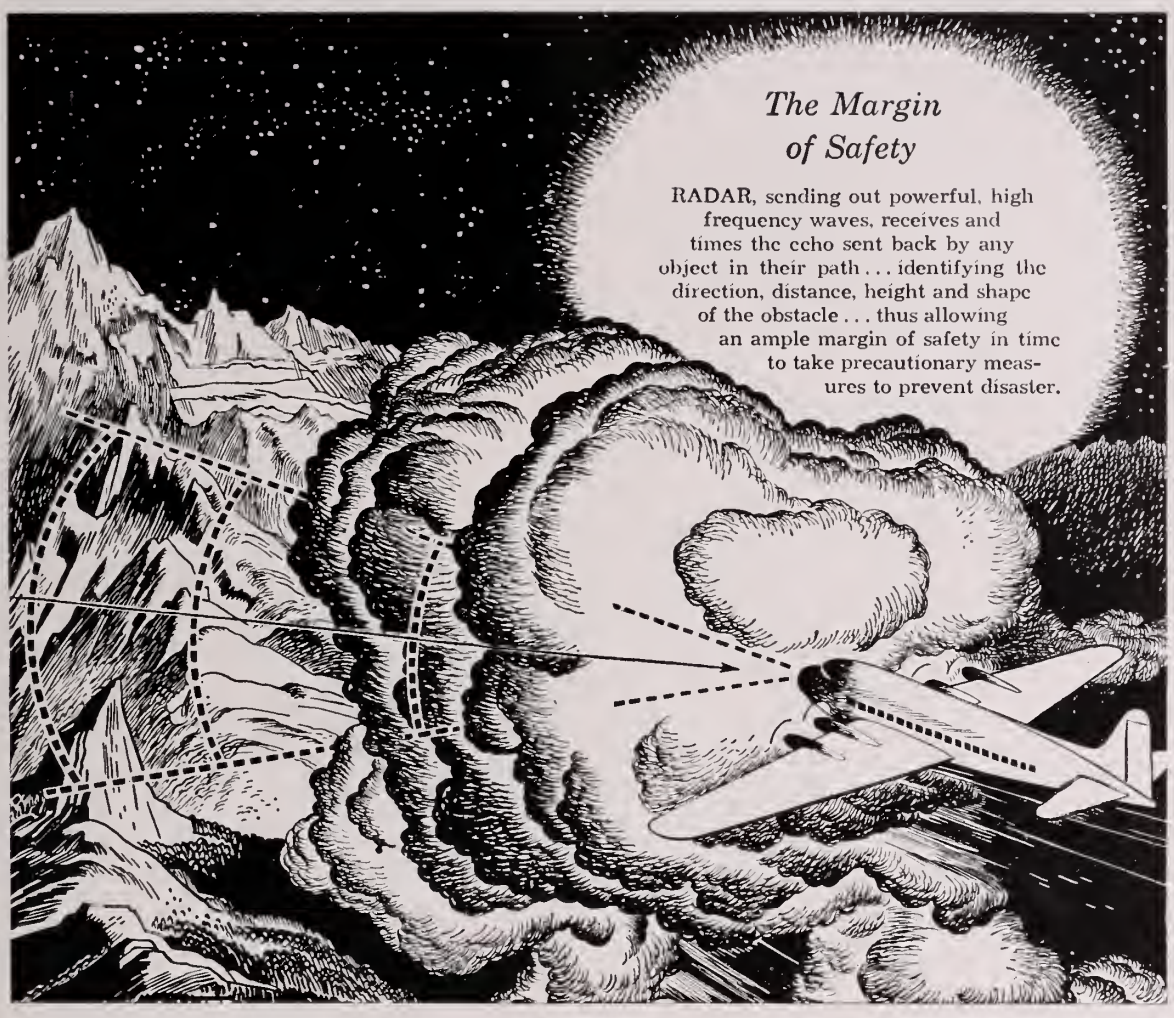
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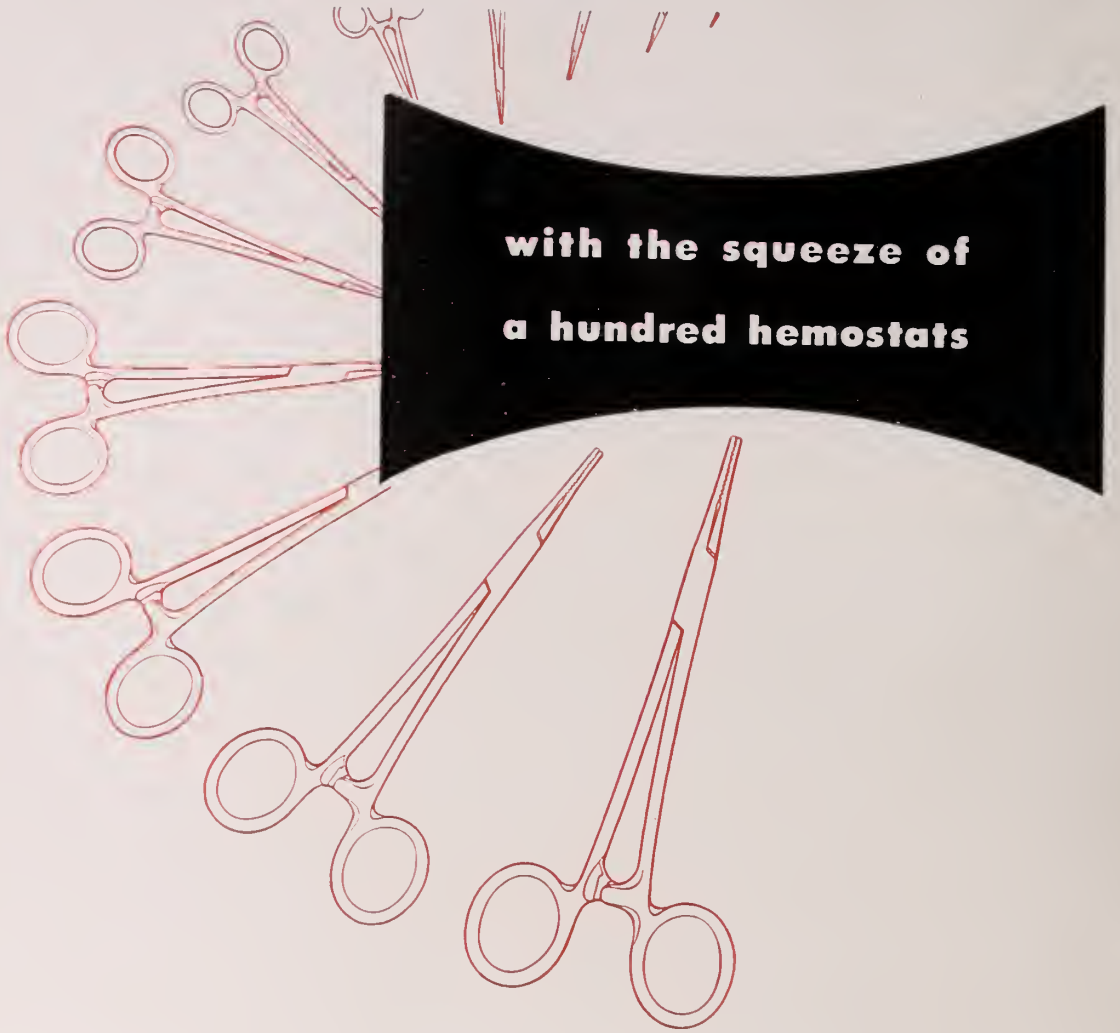
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A boy, a picture, and a dream

CHOICE OF A LIFE WORK is often a matter of circumstance. Events that seem trivial at the moment may be destined to influence the lives of generations to come. When seventeen-year-old Eli Lilly paused to study a painting of the Good Samaritan hanging over a drug store, the parable which he had learned at his mother's knee recurred to him with fond nostalgic memory. The picture inspired Eli Lilly to choose pharmacy as a career and eventually led to the founding of Eli Lilly and Company. Then the smallest pharmaceutical plant in existence, now among the largest, the success of Eli Lilly and Company must be measured largely by economic standards. Through the seventy years of its existence, however, the spirit of the Good Samaritan has never ceased to be a guiding light.

Lilly

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXIX JANUARY, 1946 NO. 1

SOME PRACTICAL ASPECTS OF THE STERILITY PROBLEM IN THE FEMALE*

GEORGE W. WATERMAN, M.D.

The Author. *George W. Waterman, M.D., of Providence. Chief of Staff, Gynecological Service, Rhode Island Hospital and Charles V. Chapin Hospital.*

BARRENNESS or infertility is said to affect about 17 per cent of married couples and is the cause of great mental distress, particularly to the female. Created anatomically, physiologically and psychologically for reproduction, she becomes greatly disturbed if her natural function is not consummated by having a child. While undoubtedly the instinct to paternity leads many sterile husbands to seek advice medically, I believe that the infertile wife has more at stake and is more often the one to start an investigation, if after several years no babies arrive. Therefore, the problem is placed, in the large majority of cases, before the obstetrician and gynecologist for diagnosis and treatment.

I propose this evening, first to review with you rather hastily the developments in the knowledge of female endocrinology as it affects the reproductive function; second, to discuss and evaluate certain tests clinical, histological, chemical, mechanical and roentgenological which are currently carried out in sterility studies; third, to show what treatment has been used with what results in 248 cases seen in private practice from 1939-1944 inclusive.

I have asked Dr. B. Earl Clarke to discuss the endometrial changes and Dr. Martineau to discuss the roentgenological aspects.

The male factor will not be considered here except to say that sperm counts have been made, perhaps not in all cases, but certainly where indicated. If irregularities as to number of sperm, abnormal forms, presence of pus or red blood cells were found, the husbands were referred to a urologist for further investigation and treatment.

Physiology, Endocrinology and Histology in the Female

Early recordings of anatomical observations of female reproductive organs are found in the writing of Fallopius and Vesalius. De Graaf (1672) has given his name to the Graafian follicle and first described the corpus luteum, although Malpighi gave name to the yellow body. Fraenkel in 1900 showed that the corpus luteum was necessary to the first third of pregnancy, fetuses in rabbits being absorbed or aborting if corpus luteum were removed. Loeb showed in 1907 that decidua formation was due to action of corpus luteum. Hitschmann and Adler (1908) described the histological changes in the endometrium during the cycle. In 1917 Stockard and Papanicolaou showed that vaginal epithelium in guinea pigs underwent characteristic changes in the estrus cycle. In 1922 Allen reported on estrus cyclic changes in vaginal epithelium of the mouse. Allen and Dorsy employed these changes as a test for study of substances producing estrus in spayed animals and found an active substance in the follicle fluid of pig ovaries and in extract of the corpus luteum. This mouse test method gave a great impetus to the study of reproductive physiology. Soon Smith and Engle and Aschheim and Zondek showed in 1926 the important and vital role played by the anterior lobe of the pituitary. Aschheim and Zondek described the anterior pituitary lobe hormone found in the urine of pregnant women and established the Aschheim-Zondek pregnancy test. Corner and Allen showed that corpus luteum extract is necessary for progestational changes in the endometrium and so gave a biological test for the presence of progestin. Later studies by Butenandt and others showed the corpus luteum hormone to belong chemically to the 17-keto steroid group. A chemical test can now be done for the excretory product of progestin in the urine, sodium pregnanediol. The findings of these investigators and many others can be put together to illustrate in a working schema a present theory correlating the activities of the pituitary with changes in the ovaries and endometrium as they appear characteristically during the menstrual or reproductive cycle as suggested by Severinghaus.[6]

continued on next page

*Presented before the Providence Medical Association at its meeting at Providence, R. I., December 3, 1945.

Some estrogenic substance is produced by the ovary from early childhood, gradually increasing in amount until at puberty a high enough level is reached so that the basophile cells in the anterior lobe of the pituitary gland are stimulated and produce follicle stimulating hormones.

1. Ant. Pit. Lobe produces follicle stimulating hormones. F.S.H.
2. F.S.H. acts on primordial follicle and produces Graafian follicle.
3. Graafian follicle produce estrogens which stimulate growth of the uterus, vagina, tubes and breasts acting most graphically on the endometrium.
4. Rise in estrin level stimulates ant. pit. to produce luteinizing hormone L.H.
5. L.H. with F.S.H. causes follicle rupture, ovulation and corpus lutem formation.
6. Corpus luteum produces progestin which causes endometrial glands to differentiate into secretory type with glycogen granules and take on progestational character. Also stimulates further the acidophiles with more L.H. production.
   L.H. inhibits further granulosa cell activity with diminution of estrogen formation.
7. The withdrawal of estrogens together with the increase in progestin results in menstruation.

Tests for Endocrine Activity

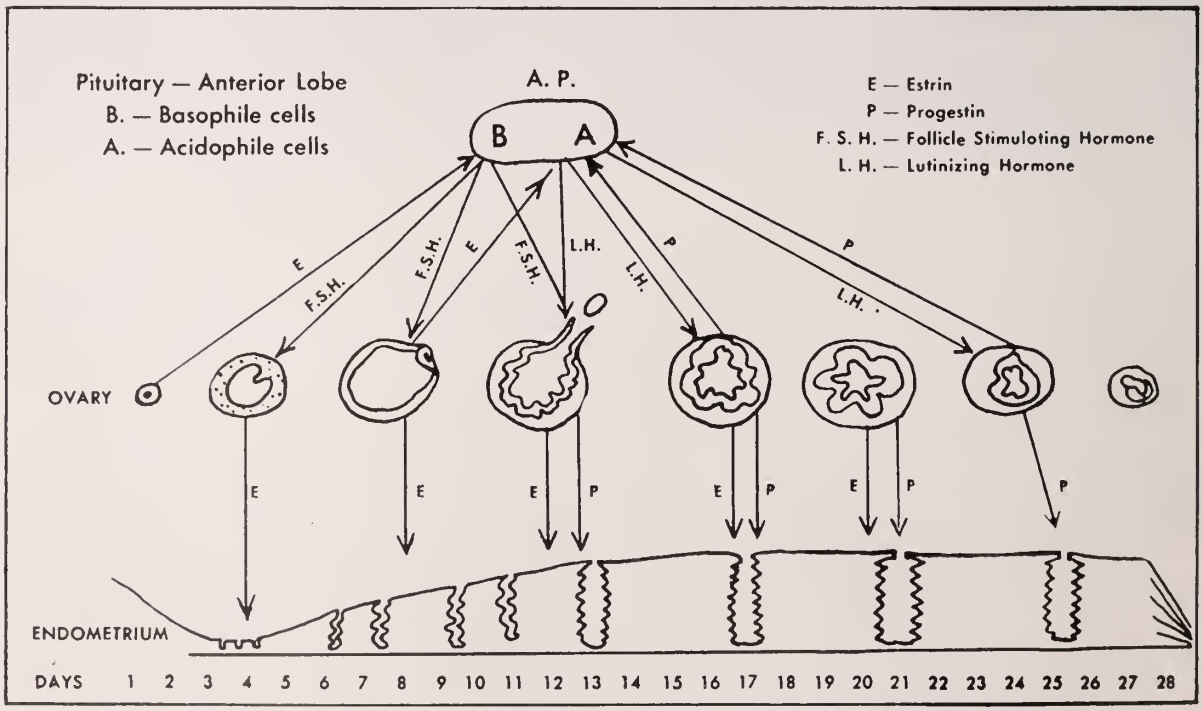
In all sterility problems, it is necessary to determine the activity of the endocrine glands involved. A consideration of the above schema will suggest what tests are necessary.

1. A.P. failure.
   Immature mouse test for F.S.H. and L.H. available in research laboratories.
2. Ovarian failure—primary or secondary.
   a. F.S.H. positive.
   b. Test for urinary and blood estrogen negative. Allen Dorsy mouse test.
3. Ovulation failure—anovulatory cycles.
   a. Test for F.S.H. and L.H. may be positive.
   b. Test for estrogens may be positive.
   c. Test for progestin — chemical test for sodium pregnanediol negative.
   d. Endometrial biopsy.

As the tests for hormones F.S.H. and L.H., estrins and progestins are not available except in the laboratories of large clinics, or research workers, we have been dependent on the endometrial biopsy as a gauge of endocrine activity.

If we consider the end product of all the endocrin activity shown in the above schema we find that in the fully developed secretory or progestional endometrium, we have an histological picture which is characteristic. When this picture is complete we

continued on page 18



Schema to show correlation of endocrine activity and histological changes in anterior pituitary, ovary and endometrium as suggested by Severinghaus and modified from Hamblen.

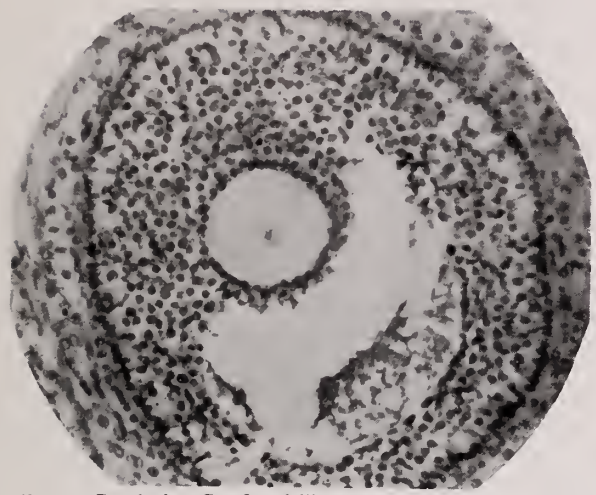


FIG. 1. Developing Graafian follicle. The ovium is seen within the discus proligerus. The central cavity containing the liquor folliculi is developing. It is surrounded by the granulosa cells which produce the estrogen.

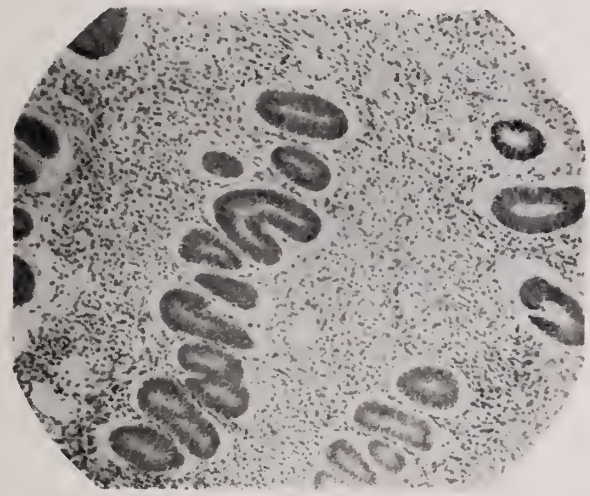


FIG. 2. Endometrium in early proliferative phase. Stimulated by the estrogen the epithelial cells proliferate. In the early phase the glands are round or oval on cross section. The cells are cuboidal. There are few mitotic figures.

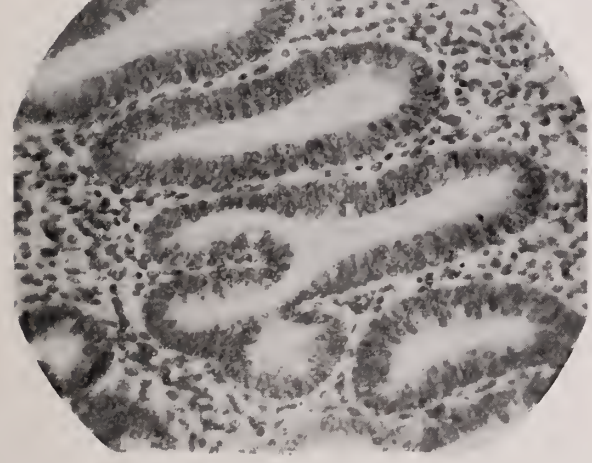


FIG. 3. Endometrium in late proliferative phase. The glands become convoluted, and the lumina larger. The cells become taller and mitotic figures are increased.

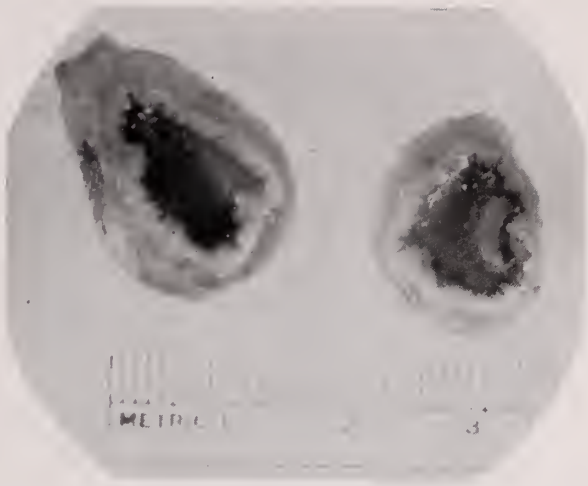


FIG. 4. Corpus luteum. After ovulation the granulosa cells are modified to form lutein cells. Grossly the scalloped, yellow lutein zone stands out in sharp contrast to the central blood clot. The lutein cells produce progesterone.

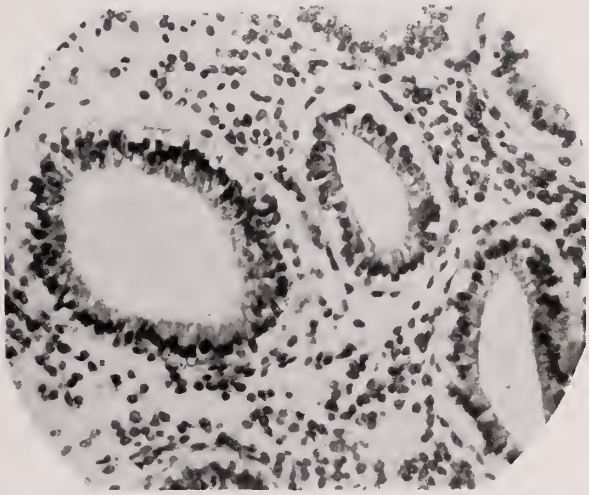


FIG. 5. Endometrium in early secretory phase. Stimulated by progesterone the glands show increasing secretory activity. This is first indicated by submuclear vacuolization. The nuclei move to the center of the cell leaving vacuoles or a lucid zone beneath them. (About the 17th day.)

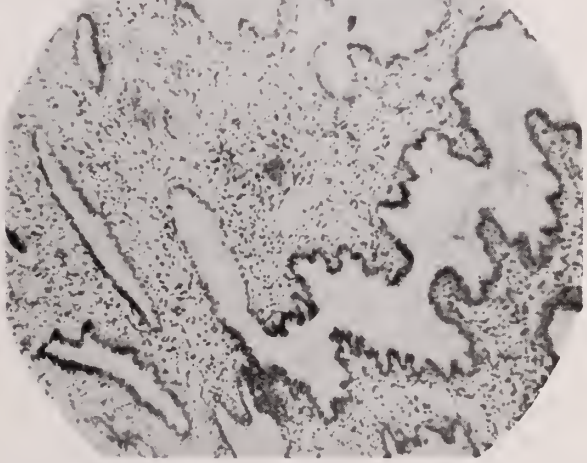


FIG. 6. Endometrium in late secretory phase. The glands become dilated and present a "saw tooth" appearance. The nuclei return to the base of the cells. The cytoplasm next the lumen becomes frayed and seems to be dissolving. The stroma becomes edematous and the stroma cells take on more cytoplasm, beginning with the cells about blood vessels (about 24th day).

know that the pituitary and the ovary are active and normal, and we can infer that ovulation and corpus luteum formation most probably has taken place. There can be some exceptions but in these the progestational picture is rarely complete. Hence we see the great value of the *endometrial biopsy* taken at the end of the period. We usually take it a few hours after menstruation has started. In this way we can be sure that we are not disturbing an established pregnancy. Also the cervical canal is more patent and the biopsy is more easily done. Of course, great care in asepsis and antisepsis should be observed.

At this point I am going to ask Dr. Clarke to discuss the histological and pathological aspects of the endometrial biopsy and to show some slides illustrating it. (See Page 17.)

Having now discussed the menstrual cycle and proved that it completes itself or not and that by inference ova are produced, we should like to know if possible when ovulation takes place—that is, on what day of the month. If we had any sure way of knowing this, at least part of our problem would be solved. We have seen a number of couples sterile for varying periods who were under the illusion that the "right time" to become pregnant was just before or just after the period. They had been trying at this time without success. A change of timing resulted in success.

Several methods of estimating time of ovulation have been found.

1. Mittelschmerz — vaginal discharge or bleeding, subjective pain or discomfort regularly occurring at midmenstruum — sometimes quite accurate.

2. Difference of electrical potential at ovulation time — time consuming for patient and doctor — not too accurate and not used in this series.

3. Daily endometrial biopsy — noting change to secretory type. Obviously this is impractical.

4. Sodium pregnanediol determination in urine. Ovulation occurs just before positive test. As ovulation rarely occurs on exactly the same date, these determinations would give no accurate clue from succeeding months.

5. Vaginal smears and pH are recommended by some but value not conclusively established.

6. *Basal Body Temperature Changes.*

The biphasic character of the basal temperature curve during the menstrual cycle was first noted in 1904 by Van de Velde. The writer first became interested in basal body temperature after reading Rubenstein's[3] article in 1940 Endocrinology. His exposition of the correlation of vaginal smear and basal temperature seemed quite reasonable and accurate, particularly the description of his four (4) cases where ovulation occurred during menstruation, suggested by basal temperature and proved correct by pregnancy resulting from intercourse at that time. Zuck[4] in 1938 showed by studies on 35 women with single exposure, that none conceived more than three days before or one day after the rise. During the estrin or proliferative phase the temperature is depressed or kept down. With ovulation, or just before, there is apt to be a sudden drop followed by a sharp rise of .4-.8 degree. The luteal phase then follows and is the most constant phase, that is, menstruation occurs usually 14 days after ovulation. The variable phase is then the proliferative and when the cycle is shorter or longer than 28 days, it is the proliferative phase that varies as is shown by these curves. Charts illustrating these curves are shown.

Having shown how we determine ovulation and its probable date, let us now turn to other causes of sterility.

The healthy sperm must meet the healthy ovum. There must be no obstruction to intromission, e.g., tough, sore hymenal ring. (One case — excised ring — soon pregnant.) Disease of the vagina, e.g., trichomonas vaginalis, or monilia alicans vaginitis which disturbs the normal pH. Infection of the cervix, endocervical discharges often cause sterility, need cauterization, electro-coagulation or conization the full length of the canal. Stenosis of the cervix due to previous operations or poorly conducted cauterizations, requires dilatation. Retroversion needs correction by pessary or in some cases operation. Chemical reactions of the pathological vagina or cervix, or incompatibility of the secretions of husband or wife may so devitalize the sperm that even if successfully deposited in the seminal pool, they do not survive. The Huhner test done at the time of ovulation is valuable in that if healthy sperm are found in the cervical secretion, one can assume that there is no chemical factor involved. If negative and the bottle specimen shows good sperm, the use of Ringer-glucose solution as suggested by McLeod has proven of great value.

Tubal Factor

Obstruction of the Fallopian tubes by disease, operative adhesions or from spasm can prevent the sperm from passing the utero-tubal junction or may prevent the ovum from entering the tube. The tubal patency test was first brought out by I. C. Rubin,[5] in attempts to produce pneumo-peritoneum by passing gas through the uterus. This method was then used for determining the patency of the tubes. Since Rubin's original work, this test has

continued on page 20

CHART 1 - NORMAL, OVULATORY CYCLES

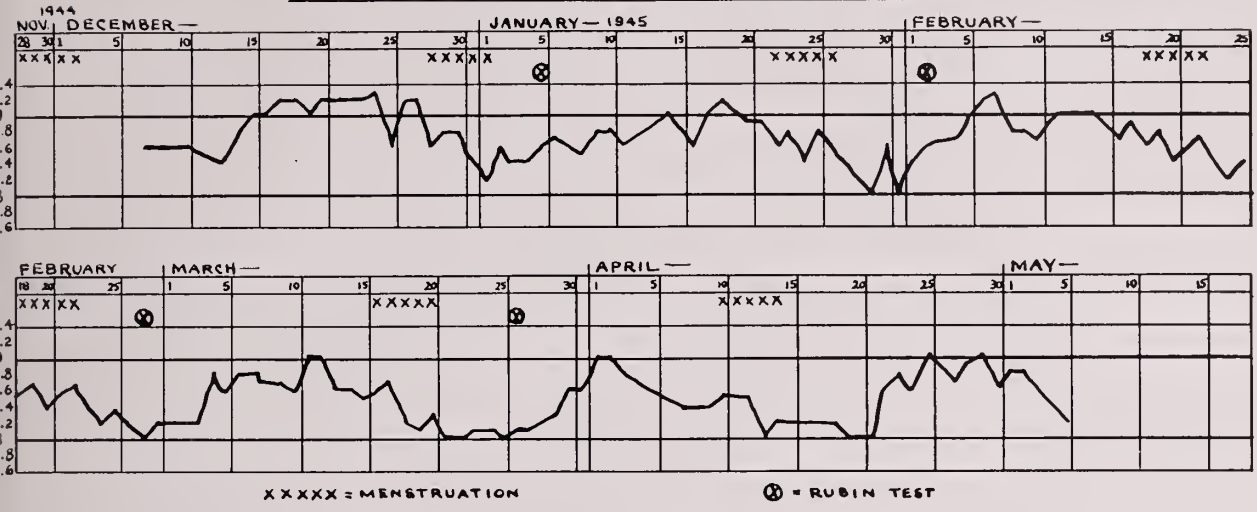


CHART 2 - PROLONGED ESTRIN PHASE, ANOVULATORY CYCLE, and FINALLY PREGNANCY

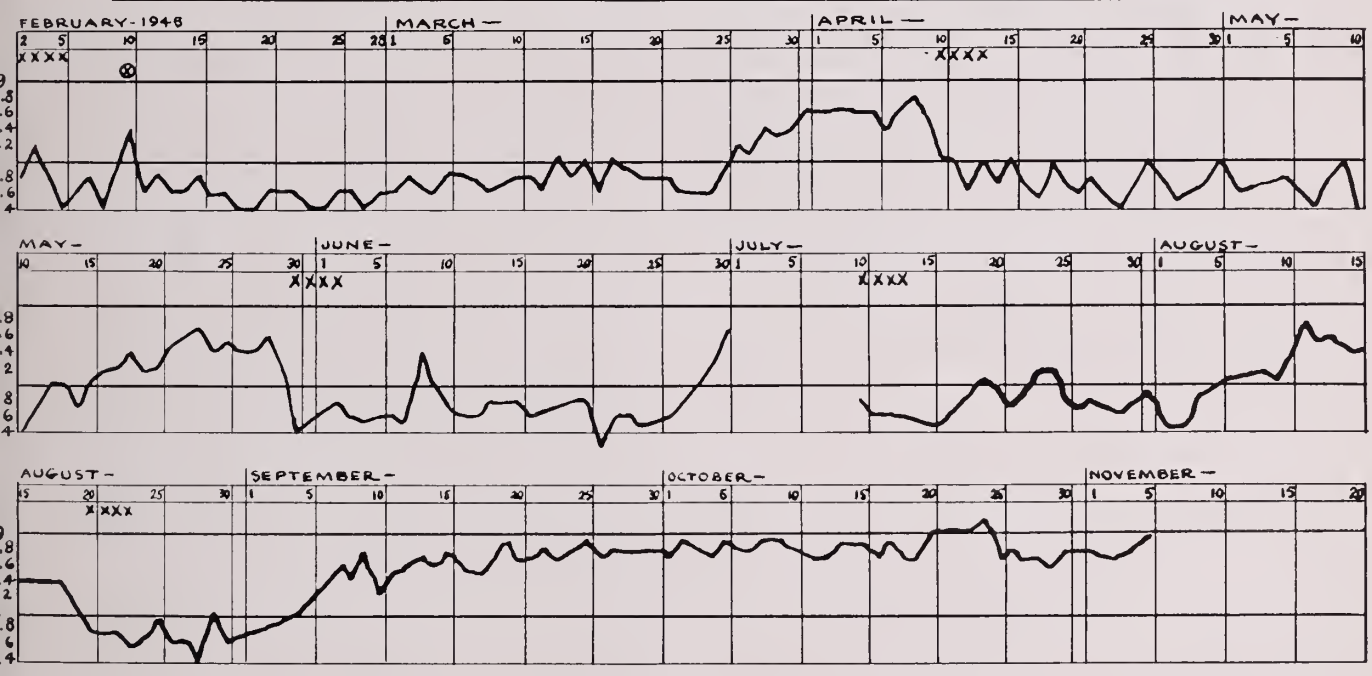


CHART 3 - NORMAL CURVE, PREGNANT IN MARCH



been widely accepted by gynecologists, and with the use of CO_2 gas and proper precautions as to its use is a simple and safe office procedure. The test is contraindicated in the case of vaginitis, acute cervicitis or where there is any tenderness or fixation about the cervix or uterus, or where there is a recent history of pelvic infection. A Rubin test has a very definite therapeutic value, in addtion to its value in diagnosis. Many pregnancies have been reported where no other treatment was employed. It is our custom to have patients come in three or four days after their period has ceased for this test. At this time the activity of the uterus is at its minimum, and there is no danger of interrupting pregnancy. Rubin has introduced the use of a Kymograph for recording the pressure variations. These tracings give a permanent record and are considered quite valuable. We have never used a Kymograph but make a record of the pressure under which gas passes through the tubes into the abdomen, making note as to whether the fall of pressure following is rapid or slow. Oscultation of the lower quadrants, subjective symptoms of pain, mid-line or on either side indicate passage or non-passage of the gas. Shoulder pains after rising to the erect position is indicative that gas has passed into the peritoneum. If we find on examination that the Rubin test is negative, the next step is the injection of the uterus and tubes with opaque media, and the observation under the fluroscope and by stereoscopic X-ray pictures.

Dr. Martineau will discuss the Roentgenological aspects of this procedure. See Dr. Martineau's discussion on page 21.

Results

1939-1944

Primary Sterility		190
Relative Sterility		58
Total cases		248
Cases seen more than once		197
Pregnancies (Primary Group)	50 — 26% uncorrected	
" (Relative Group)	15 — 26% "	
" (Total)	65 — 26.2% "	
Pregnancies	65 — 33% corrected	
Ectopic	2	
Early abortion	5	
Live births	58 — 29.5% "	

Results obtained in any series of sterility cases are always difficult to evaluate. Many patients are known to become pregnant without treatment even after many years. On the other hand many patients are seen only once, or possibly twice, fail to report back or follow instructions or move away before sufficient time has elapsed, and are lost track of. Some of the patients in this series came in for the Rubin test alone and returned to their referring doctor. Of the 248 cases seen from 1939 to 1944, 51 did not complete the planned treatment and study. Of the 197 cases who were thought to have had a fairly complete study and treatment, 65 or about 33% become pregnant. The following table shows the results where different methods of treatment were used. Many of these patients had several different kinds of treatment and many of them had more than one factor involved in their sterility. It should be noted especially that the thyroid factor is a most important one. Basal metabolism tests should be done on the majority of these patients. It will be noted that of the 65 patients who were treated with thyroid extract because of lowered thyroid activity 43% became pregnant. This figure is in agreement with the reported results of other observers.

		Pregnant
Deficient sperm	52 — 29%	12 — 23%
Electro-coagulation of cervix	120 —	33 — 27.5%
Dilatation of cervix	23	4
Rubin test	202	51 — 25%
Lipiodol	17	4
Precoital douche	37	11 — 30%
Pessary — retroversion	17	6 — 35%
Diet obesity	15	6
Thyroid	65 — 26%	28 — 43%
Ectopic Pregnancy	2 cases	

1 — M. 8 mo. Rubin test 10-21-43 Ectopic 3-29-44
2 — M. 2½ yr. Rubin test 11- 4-41 Ectopic 7- 8-42

The use of the commercial gonadotropes—e.g. pregnant mare serum and pituitary extracts have been employed cautiously in a few cases. Their status is still uncertain and waits further trial in research clinics before being tried out by clinicians.

Summary and Conclusions

A discussion of the endocrine aspect of sterility has been given. An evaluation of the endometrial biopsy, and the basal body temperature chart as tests of ovulation and the time of ovulation given. The value of the Huhner test in proving the deliverance of the sperm into the cervix has been discussed. The Rubin test for patency of the tubes has been discussed as to its diagnostic and therapeutic value as has the lipiodol hysterosalpingogram. Results on total number of cases 248 seen and on 197 cases adequately examined and treated have been given. Particular attention is drawn to the excellent results obtained where the thyroid factor was apparently at fault.

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UTEROTUBOGRAPHY IN STERILITY*

LAWRENCE A. MARTINEAU, M.D.

The Author. *Lawrence A. Martineau, M.D., Director Department of the X-Ray, Rhode Island Hospital.*

THE visualization of the uterine cavity and lumina of the tubes with contrast media, commonly referred to as uterotubography, or Hysterosalpinography has become a widely accepted procedure in the study of female sterility. Cary and Rubin, as early as 1914, attempted to radiographically visualize the fallopian tubes with collargol without much success, and up until 1925 various other substances were used for this procedure but they all proved unsatisfactory. The use of iodized oil as a contrast medium for uterotuboraphy was reported in 1925 and the following year Benedict and Rubin were the first in this country to use lipiodol for determining tubal patency.

The technique of injecting the opaque media has been modified considerably since the original work of Rubin and for about the past year the iodized oil has been injected under direct vision by fluoroscopy. No manometer is used, as the injection is



FIG. 1—Antiflexed uterus. Normal filling of the uterine cavity and fallopian tubes.

made by thumb pressure and the tension regulated by the filling of the uterine cavity and the subjective symptoms of the patient. The normal uterus and tubes (fig. 1) may be adequately filled with about 6 cc. of contrast media but the uterine cavity may vary considerably in size. Therefore injecting



FIG. 2—Normal uterus. Occlusion of both tubes at their cornual ends.

the oil by this procedure should eliminate some of its dangers as, intravasation which is due to undue pressure resulting in rupture of the endometrium with escape of oil into the uterine vessels. When this occurs, there is always possibility of oil emboli. The danger of rupture of the tubes, has been reported in only a few instances but probably occurs more frequently than suspected and is believed due to a weakening or thinning of the walls of the tube from disease. The danger of infection should never occur in normal cases and in capable hands.

The contraindications for uterotubography are the same as for tubal insufflation, and they are of such importance that they bear repeating at this time. Genital tract infection is the greatest contraindication to the test, and therefore the patient should be carefully studied before given an appointment for the examination which is usually done 10 to 12 days after the menstrual period. Other contraindications include pregnancy, pelvic neoplasm accompanied by marked uterine bleeding, and advanced pulmonary or cardiac disease.

continued on next page

*Presented before the Providence Medical Association at Providence, R. I., December 3, 1945.



FIG. 3—Normal uterus. Tubes show kinking and slight constriction near their outer ends.

In addition to its diagnostic value in tubal patency, the test may also be of considerable aid to the gynecologist in prognosis. However, with closure of both tubes, particularly at their cornual ends, (fig. 2) an unfavorable or discouraging report is not warranted unless the test has been repeated after the use of antispasmodics. It must also be remembered that a return of tubal patency has been noted in patients following one or more injections of the iodized oil.

The therapeutic effect of the test in restoring the patency of the tubes compares favorably with uterotubal insufflation, and is believed due to mechanical means which consists of breaking up kinks or adhesions. This frequently occurs in cases of partial obstruction or stenosis, (fig. 4) where there is retention of oil in the tubes with a small amount in the pelvic cavity, as seen in the follow up films



FIG. 4—Same case as 3. Slight amount of oil in the pelvic cavity with retention of oil in outer ends of both tubes due to adhesions.



FIG. 5—Normal uterus. Marked bilateral hydrosalpinx.

taken a considerable time after the injection of the contrast media. The fact that some patients conceived following uterotubography, whereas the Rubin test disclosed non-patency only a short time before, does not necessarily mean a superiority of this test over insufflation, for it may be due to tube spasm at the time of the first examination or other interference with patency due to mucus, old blood or slight adhesions.



FIG. 6—Same case as 5, film taken 24 hours after injection. No free oil in the pelvic cavity. Obstruction of both tubes due to hydrosalpinx with retention of oil in their dilated outer ends.

The obstruction of the tubes occurs most frequently at their distal ends, and if a plastic repair for restoration of tubal patency is considered uterotubography is indispensable in localizing the obstruction.

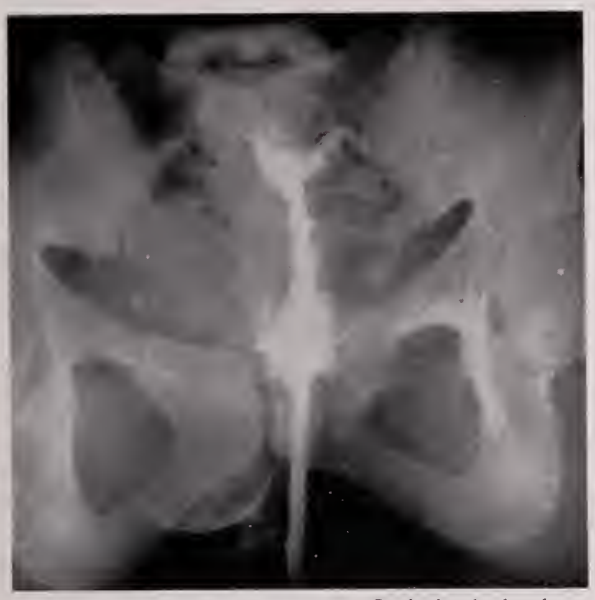


FIG. 7—Small bicornuate uterus. Occlusion both tubes and calcifications in the region of the ovaries due to tuberculosis.

Summary

Uterotubography, like the Rubin test, has become a widely approved procedure in the diagnosis, prognosis and therapeusis of sterility.

All of our patients had previous utero-tubal insufflations, and this test was performed only as supplementary procedure in doubtful or known cases of non-patency, which accounts for our poor therapeutic results.

Uterotubography is superior to insufflation, when salpingostomy is contemplated, and also in doubtful cases when it is desirable to know if both tubes are patent.

The test is safe if performed with a knowledge of the dangers and contraindications, as statistics show a morbidity of about one-tenth of one percent, while infection has occurred in less than one-half of one percent of all cases.



FIG. 8—Chronic endocervicitis. Antiflexed uterus. Right tube obstructed at fimbriated end and left tube obstructed at its cornual end.

Mid-Winter Meeting

The Rhode Island Medical Society

and the

Providence Medical Association

MONDAY—FEBRUARY 4—8:30 P.M.

At the Medical Library

PROGRAM

"MEDICAL CARE FOR THE VETERAN"

Major General PAUL R. HAWLEY, MC

Acting Surgeon General, U. S. Veterans Administration

* * * *

"THE PLAN FOR A VOLUNTARY SURGICAL INSURANCE PROGRAM FOR RHODE ISLAND"

HERMAN C. PITTS, M.D.

President-elect, Rhode Island Medical Society, and Chairman, Surgical Study Committee

PRESIDENTIAL ADDRESS*

B. EARL CLARKE, M.D.

The Author. *B. Earl Clarke, M.D., of Providence. Pathologist, Rhode Island Hospital. President, Providence Medical Association, 1945.*

THE by-laws of the Providence Medical Association, Article 1, Section 2, reads: "The President shall deliver before the Association at the annual meeting an address with special reference to the work and needs of the Association." With considerable reluctance I attempt to carry out that charge.

The review of the year's work may be quickly disposed of. All regular monthly meetings have been held and in spite of difficult war-time conditions, it is my opinion that the attendance has been good.

At these meetings we have listened to scientific presentations by seven of our own members and six guest speakers. This does not include the joint meeting with the Rhode Island Medical Society in February.

At the beginning of the year I appealed to our members asking for volunteers who were willing to read papers. The response was most gratifying. We were unable to use all of these voluntneers. We have attempted to so choose the subjects and correlate them with the topics of our guest speakers as to have an interesting and well rounded year. Without an excess of material such choice would have been impossible. We are, therefore, just as much indebted to those who did not appear on the programs as to those who did. We wish to emphasize our appreciation for this cooperation and to assure each one that his effort was not wasted and not overlooked.

These regular scientific meetings are, in my opinion, the most important activity of our Association. The return of our members from the military services with resulting increase in numbers and correspondingly lighter burdens should result in better programs and larger attendance.

The joint meeting with the Rhode Island Dental Society, in November, was the first of its kind. Some dentists and some physicians believe that dentistry should eventually become a medical specialty, analogous for example to ophthalmology. This is spoken of as the Harvard plan. Even if this does not come to pass it is desirable that the two groups become progressively more closely associated. I suggest that careful consideration be given to the desirability of making this joint meeting an annual event.

Early in the year a committee on air pollution abatement was appointed. The objectives of this committee met with much public approval and support. A large sponsoring committee made up of representatives of important community groups and organizations was formed. With very few exceptions all such persons approached were enthusiastically for this project. The Mayor and the Public Service Engineer expressed interest and willingness to cooperate. The Civic Planning Board of the Chamber of Commerce was not only interested but ready to help. A small subcommittee has been doing spade work and laying foundations. Out of all this has come the recent appointment by the Mayor of an official committee of five to study the problem. Dr. Edward Cameron, chairman of our committee is a member of the Mayor's committee. We are now marking time pending action by this new group.

This is a long time project. It must not be allowed to die of inertia. I strongly urge that the Air Pollution abatement committee be continued on a permanent basis and that the Association go on record as being determined to keep this project alive and to seek continuous improvement in the air which the citizens of our community must breathe.

Quite recently I have become aware of a weakness in our organization. As the largest constituent member of the Rhode Island Medical Society, we are entitled to representation by twenty-nine members of the House of Delegates of that Society. The large size of this representation has resulted in awkwardness and inefficiency. What is everybody's business becomes nobody's business. I suggest that this group be organized with such officers as a chairman and a secretary; that they meet together preceding the meetings of the House of Delegates so that they may consolidate their opinions and adequately present the desires and instructions of this Association; and that a procedure be formulated whereby they routinely report back to the Association concerning the activities of the House of Delegates.

*Presidential address delivered at the 99th Annual Meeting of the Providence Medical Association, at Providence, January 7, 1945.

The Rhode Island Medical Library is one of our most valuable assets. While it is the property of the State Medical Society, it is obviously, because of location, of greatest value to the physicians of Providence. Much of its potential value has been denied us because it is closed after 5 p. m. Your Association has completed arrangements whereby the library is to be open three nights per week during the coming year. Whether or not this plan may be continued permanently depends largely upon how much we take advantage of this opportunity to use our library. It is my hope that the evening hours will be so popular that three nights a week will seem too few.

Two projects have come to my attention during the year that I feel the Association should investigate further. One of these is the suggestion of establishing in Providence a Health Museum similar to that in Cleveland, Ohio. This would be a large undertaking and would require the cooperation and financial support of many organizations and individuals. The Providence Medical Association could only promote it. One possible source of financial support for such a project has already expressed interest. Such a museum, it seems to me, offers unlimited opportunity for medical education and for the creation of good will and understanding between the medical profession and the public.

A second project that I believe to be worthy of serious consideration is that of a medical telephone exchange, controlled by the Association and offering better service to a much larger number of doctors.

These local concerns are of immediate but perhaps of secondary importance. As an organization and as individuals we are vitally involved in those national and world-wide concerns that are included under the term reconversion. Reconversion. Let us consider that word for a moment. Webster defines reconversion thus: "to return to an original form or condition." But the real meaning of this word is found not in the dictionary but in the hearts and acts of men and in the spirit of the people who use it.

The people of America are not seeking to return to an original condition. The goal is for something bigger and better. Industry is hoping for unprecedented production, distribution, and profits. Labor expects increased wages, a higher standard of living, and less work per individual. We are planning for a world organization that will outlaw war and guarantee permanent peace.

There is, apparently, singleness of purpose, but great lack of agreement as to methods. Political and social changes seem to follow trends which sometimes prove to be right and to lead to permanent improvement, and sometimes to be wrong and to greatly delay progress, or even to cancel improvements already made.

We are today in the midst of such a trend. This trend might be designated as the Social Security panacea. It is, to my mind, a travesty of legitimate social service. Social service as originally conceived was a most desirable and admirable effort to help those unfortunate individuals who, for one reason or another, were unable to care for themselves. It was quite natural that out of such a beginning there should come to be a growing group of persons engaged in such work and that eventually such persons should form an organization and seek to establish standards of education and experience prerequisite to membership in the group. It was equally to be expected that as the group of social service workers grew and became more and more imbued with the idea that they were doing something worthwhile, they should seek to expand their field of endeavor. This expansion could proceed only so far as the supply of those unable to care for themselves permitted. It therefore became necessary to include persons who in the beginning were not considered among the incapable.

Such expansion would probably not have been carried too far by this original group, but politicians were quick to see the vote-getting possibilities of such a set-up. As a result it would now appear that the great majority of the citizens are to be labeled as incompetent and are to be relieved of personal responsibility by a bureaucratic form of government under the name of "Social Security." Any such attempt to reduce all men to the same stature is, in my opinion, just as undesirable and eventually will prove to be just as disastrous as the infamous Procrustean bed of mythology. Such a program destroys individuality and drags all things down to the level of the lazy, the uninspired, the shiftless, and the dull. "Pump priming, subsidies, unemployment insurance, and social security laws are indications not of national strength but of an alarming fundamental weakness."

If offered such a program as a whole, the great majority of American citizens would reject it with horror. When offered bit by bit with emphasis placed upon the social benefits, many fail to see the inevitable consequence. The Lilliputians by the multiplicity of their tiny thread-like fetters were able to securely bind the giant Gulliver. The advocates of these new schemes fail to point out that in order to accomplish the proposed advantages we must consent to letting government order us around a little more. Thus, in connection with universal military conscription, regardless of all other arguments for or against, the fact remains that it exposes the youth of the nation to regimentation and conditions them for totalatarianism. The man who served six months in a secure post in this country

continued on next page

is often the most voracious in his expectations and demands for governmental aid as a "veteran."

What has all this to do with the Providence Medical Association? A great deal. Medicine is at the moment caught in the center of the stream of this totalitarian trend. It has been thrown there by politicians because of its strong emotional and personal appeal. No one can deny the desirability of health and medical care for all. The purposes are so wonderful that few stop to consider whether they are attainable or to count the cost. The medical profession is opposed to the Wagner bill not only because it questions the method, but equally because it knows that the advantages promised cannot be attained and because it feels that it would be a long step toward total regimentation.

What can we do about it? When a wise swimmer is caught in a strong current he does not attempt to swim against it or even squarely across it. Instead, he floats with the current and pulls toward the shore until some strong object is found which he can grasp and hang on to until the flood subsides.

Medicine in her present predicament has seized upon voluntary medical insurance as this something to hang on to. Such a plan is being prepared in Rhode Island and we must support it.

However, this is only a temporary expedient. The important thing is to stem the tide of the trend toward totalitarianism. We have just completed a war to prevent this from being imposed upon us by others. Shall we now blindly permit it to be gradually and insidiously thrust upon us by those who like Anne Lindbergh believe it to be "The Wave of the Future" which we are powerless to prevent?

It is true that the sources of this trend lie far beyond the field of medicine. They are based upon nationalism and the resulting need of great armaments, upon a deadly propaganda which crushes individuality under a paternalistic state in the name of patriotism, upon the creation of huge, hideous industrial cities whose immense populations have no economic security and no contact with nature and the enduring things of life, upon an economic system that encourages installment buying and perpetual debt, upon the loss of great moral and religious principles that teach universal good will and the brotherhood of man. No; these things are not medical, but they threaten the future of medicine.

The eventual outcome depends upon education. When a man knows the facts and is able to distinguish between truth and false propaganda; when he comes to put spirit above material things; when he experiences a true sense of humanity he will not be attracted by such perverted ideas. Gold and silver are not attracted by the base metal iron, even though it is magnetized.

Men of medicine both as groups and as individuals can do a great deal to remedy this regrettable situation. In fact, there is probably no other group, of equal size, which exerts such a great influence over their fellow men. This places upon us a great responsibility. We must endeavor to keep our own house in order. Science alone, for a medical man, is not enough. The spiritual values of life are still of first importance. Sincerity, sympathy, sobriety, responsibility, integrity, ethics, high moral and social standards are always an important part of the physician's equipment.

We must maintain the confidence of the people and demonstrate the superiority of the democratic way. Medicine has always ignored national boundaries. Only during the war were the discoveries of medicine concealed and denied to a part of the world. When politicians and economists, yes, and men of religion can emulate Medicine's spirit and practice of universal brotherhood, we can hope for an end of wars and for the development of true world democracy.

I close with the words of the immortal Washington: "We must establish principles that are so high that courageous men will aspire to them and leave the rest to God."

SURGICAL UNIT AT CHAPIN HOSPITAL

Recently Mayor D. J. Roberts reported details for developing a temporary surgical unit at the C. V. Chapin Hospital after a meeting of the Board of Hospital Commissioners which has decided upon the plan to ease conditions caused by the shortage of hospital beds in the city. With wards A and B at the hospital not used much in recent months the Commissioners decided that elective surgical cases of a non-emergency nature might be treated.

In reporting the plan Mayor Roberts, speaking for the Commission, was reported as stating that in the neighborhood of 1000 cases a year could be treated in Wards A and B. The temporary unit might last a year or five years, depending upon the time it takes for other hospitals to increase the hospital bed capacity of the State. Private and semi-private cases only, such as those with Blue Cross coverage, would be admitted he said, because there appears to the Commission to be sufficient beds in other hospitals for ward cases.

Chapin Hospital has had various surgical services in the past, he stated, but not a surgical ward or unit as such. Establishment of the unit depends, he further reported, upon when sufficient nursing staff can be gathered.

At its meeting the Board of Hospital Commissioners adopted three motions governing the operation of the surgical ward. One of these limited the cases handled to the elective type. A second limited use of the surgical ward, "when in order," to members of the hospital's surgical services and to those on the consulting staff listed as consulting surgeons in the departments of urology, gynecology, surgery, orthopedics, ear, nose, and throat, ophthalmology, dentistry, and anesthesia. A third permits any surgeon to employ his own assistant and anesthetist even though they are not members of the Chapin staff.

The RHODE ISLAND MEDICAL JOURNAL

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THE RHODE ISLAND CASH SICKNESS COMPENSATION ACT

The Rhode Island Cash Sickness Compensation Act declares that "An individual shall be deemed to be sick in any week in which, because of his physical or mental condition, he is unable to perform any services for wages". One year later (1943) the Act was amended to read as follows: "... provided, however, that an individual shall be deemed to be sick in any week when such sickness prevents him from being able to perform his regular services, even though such employee is paid his regular wages or parts thereof by his employer, for which absence is due to sickness". Clearly there is some confusion here, for in the first place an individual is said to be sick when he is "unable to perform *any* services for wages"; in the amendment he is said to be sick when he is "unable to perform his *regular* services". This confusion of statement, notwithstanding, it is fair to assume, and in practice, physicians do assume, that the Legislature intended to make compensation available for a limited period of time, to any workman who, because of illness or injury, is unable to work at his last, customary or reasonably similar occupation. Certainly all physicians realize and applaud the spirit of benevolence that led to the enactment of the Cash Sickness Act; for no one better than they knows the hardships, the privations and the heartaches which may result from illness and injury. For the physician, daily familiarity with these things breeds, not contempt, but compassion.

Long experience has taught the physician how intimately blended are the good and the bad in humankind. He knows, for example, despite the philosophers, that the average man is, for the most part, not so much a rational, as he is an acquisitive lazy animal who is all too frequently looking about for some substitute for work. Again, and this too, from his daily experience, the physician knows that when there is a financial reward for being and remaining ill, there will surely be a plentiful supply of illness. When illness or injury becomes an asset instead of a liability, there is aways the subtle temptation to transform the will to be well into the will to be ill. And when one may collect for an injury, not Workmen's Compensation only, but also Cash Sickness benefits it is demanding too much of human nature to ask it to eschew such an alluring opportunity. Strange as it may seem, it is none the less true, that many people prefer to remain comfortably ill for less than their regular pay, rather than to submit to the unpleasant discipline of work. For these and for many other like reasons, we physicians are only too willing to confess that we are perplexed; and we shall be very much

continued on next page

obliged to anyone who is wise enough to tell us who is physically and mentally ill, and who is not; furthermore, we shall be doubly grateful to him who will inform us how to decide when a person, allegedly ill, is actually able to return to his work.

We are not speaking of those worthy and honest people whose illness or injury is really such that no one can or wishes to deny to them all available helps. The same may be said of those who are frankly psychotic. It is not these who stretch the pia mater of the physician in his conscientious efforts to further the just administration of the Sick Benefit Act. Who then are the people who make the signing of sick benefit forms anything but an agreeable duty? They are the cunning malingerers, always on the make; the hosts of neurotics enveloped by a nimbus of self-pity; the constitutionally inadequate who never have been and never will be able to meet the exigencies of life; the mentally dull and the near-dull who cannot swim in the swift stream of modern industry and commerce; the chronic complainers and the perpetually juvenile for whom the world is out of joint; the paranoids who are forever either giving or taking offense; and last, but by no means least, the frustrated and the disillusioned who are reluctantly discovering that their former idols are disclosing feet of clay.

Now all of these people are likely to obtain jobs. They have no hernias, no bad hearts, no tuberculosis; their arms and legs are intact. The preemployment medical examination, if such there be, does not weed them out as being unfit or undesirable. They work for a time and then fall "physically or mentally ill". Thereupon they demand Cash Sickness benefits "because of their physical or mental condition": and because also, as many of them have been heard to remark, "They took it out of my pay; it's coming to me and I'm going to get it". When these persons turn up in the doctor's office he realizes that he is sitting uneasily on the horns of a dilemma. If he refuses to sign their applications they depart elsewhere but not before they have damned him with no praise; if he certifies that they are ill, he has the feeling that he is probably saying what is not really true.

Well then, what is the physician to do? And what are the harrassed lay administrators of the Cash Sickness Compensation Act to do? Since this is an untidy world, and apparently becoming more so every day, no doubt they are going to do the best they can with very recalcitrant material.

Were it possible, which it is not, to set up definitive standards of physical and mental illness, then perhaps cash benefits could be denied to those who should not rightfully receive them. But as things are at present we have no certainties but only opinions to guide us; and as everyone knows, it is of the essence of an opinion that it may turn out to be wrong. There is the patient's opinion that he is ill and unable to work; the opinion of the attending physician; the opinion of the Board's own examining physician; the opinion of the Board itself. So therefore, the administration of the Cash Sickness Act is carried on in a climate of what may be conflicting opinions. It is this situation which makes the physician's efforts to be reasonable and just so exceedingly difficult.

Not that we are complaining. The physician is always confronted by what amounts to no more than probable evidence; and upon this he must of necessity base his opinions and actions. Nor are we disposed to querulous criticism; for we are well aware that we live in no Utopia. We are but relating some of the difficulties which beset our professional path, difficulties unknown to those voluble layfolk who so cavalierly criticize us. And now, in addition to our ancient and proper task as practitioners of the art of healing, we are required to exercise a judicial function, for we are asked to decide who is and who is not able to resume his work. If therefore, we sometimes differ among ourselves in our judicial opinions, because experience is misleading and judgment difficult, may it not be for the reason that the Cash Sickness Act is as laudable in inspiration and motive as in practice it is difficult of application.

ADVERTISING IN STATE MEDICAL JOURNALS

The Cooperative Medical Advertising Bureau was established some years ago by the American Medical Association to aid the advertising in the state journals. The big national advertisers would arrange through this bureau to distribute their advertisements in the different journals. This freed the members of the work of personally soliciting advertising. The fees were collected by the Bureau and distributed among the members. Nearly all the state journals entered into this scheme.

The trustees decided that only those medical products that were approved by the Council on Pharmacy would be acceptable for advertising. But as time went on certain of the journals accepted the advertising of products that had not been passed on by the Council. Indeed, something like 78 per cent of the journals did this at one time or another. They felt they had good reasons. Certain articles were known to be in common use by the best men in the profession, but yet for one reason or another the Council had not got around to passing on them. These articles had not been rejected by the Council. They had just been ignored. These conflicting viewpoints caused a climax this fall

when the editors received a telegram from the Secretary of the Board of Trustees stating that because of all this the Cooperative Medical Advertising Bureau would probably be abolished on December 31.

Now the journals had, to represent their interests, an advisory committee originally three in number, later increased to five, chosen by them from their members. This committee called a meeting of the editors and business managers to be held in Chicago on December 1 just before the meeting of the House of Delegates of the American Medical Association, that they might decide what their answer would be to the Board of Trustees.

The advisory committee suggested for their consideration three alternatives.

> 1. The Bureau may be continued as an activity of the A.M.A., under the entire control of the Board of Trustees and discontinue the elective members of the Advisory Committee. In other words, the Bureau could be relinquished entirely to the Board of Trustees without voice in or participation of the member Journals other than accepting the advertising forwarded by the Bureau, the distribution of income to be made as at present.
>
> 2. The Bureau may be continued as an activity of the A.M.A. with an Advisory Committee constituted essentially as at present, with reasonable liberalization of the present advertising rules as far as concerns nationally advertised products of demonstrated worth, provided a satisfactory working agreement can be evolved by the Board of Trustees and the elective members of the Advisory Committee.
>
> 3. The establishment of a cooperative advertising (and advisory) bureau entirely separate and apart from the A.M.A. to be managed by an executive committee chosen in a manner essentialy as the elective members of the Advisory Committee are now selected. This executive committee should have entire control and management of the bureau and should meet often enough to keep close contact with all its affairs and activities. The decision of the Executive Committee as to advertising should be final, with the proviso that each journal is autonomous to the extent that it may accept from the products approved by the Executive Committee only such articles as are approved by its own publication committee, as is now in vogue as to alcohol and tobacco products. In other words, if a journal so desires, it may limit its advertising strictly to council approved products.

The results of their discussion was that they chose No. 2 for their course of action.

The next day they met with the Board of Trustees. The Trustees informed them that it was their intention to maintain their standards as laid down by the Council on Pharmacy and members of this Council explained their viewpoint. Apparently there was no intention to "liberalize" their action on disputed products. The Trustees also announced that they had removed the Managing Director of the Bureau who had served since its inception. This came as a startling piece of news to all connected with the state journals. The Advisory Board evidently had not been consulted and knew no more than the humblest official of the journal of the smallest state. And yet the salary of this director and all his expenses were paid from the money which we, the state journals, had earned.

The immediate cause of dispute is the question as to what things shall be advertised in the state journals. Here the situation seems illogical. The editor of the Journal of the American Medical Association, whose books advising people regarding illness are published by the thousands, has admitted that he has used in his family well-known pharmaceutical products that we cannot advertise. And yet that journal carries advertisements of a well-known brand of cigarettes extolling their medicinal value.

But that is not the major issue. This is supposed to be a Cooperative Medical Advertising Bureau. We have small Latin and less Greek, but we know that "cooperative" means working with. The telegram mentioned above said in no uncertain terms that we had better *play* with the trustees—or else. Working with them is something else. Members of our "advisory committee" drop their practices and travel without pay to Chicago from points as far away as Colorado, West Virginia and New England. The trustees consulted with them not at all before announcing that they would probably disband the Bureau at a few months notice. What matter could there be more vital to our interests than the firing of the business manager of the Bureau and the hiring of his successor? Yet the job had been done before we started for Chicago, and one long business meeting had been solemnly gone through with before the "advisory committee" learned of it. If there is a male hormone that has passed the Council on Pharmacy, this thoroughly emasculated committee needs treatment.

All this may seem to our readers a bald and unconvincing narrative of medical politics in Chicago, but advertising means much to this journal. We hope and believe that you all study our advertising pages. Undoubtedly some of you find them more interesting than the editorial pages. Of course; great corporations spend much money to make them so. But don't forget that medical men have reason to believe these products are worthy or they do not get access to our pages.

The A. M. A. protests vigorously against the centralization of authority at Washington in the conduct of medicine. Where could a more perfect example be found of a "dogmatic totalitarian hierarchy" than the Board of Trustees in their conduct of the "Cooperative" Medical Advertising Bureau? The Board of Trustees are a fine group of men picked carefully from the best of the profession. They make great sacrifices that they may have the time and energy to work for organized medicine and through it promote the interests of all our people. But being human they can make mistakes

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COURT DECISION ON SICKNESS ACT ELIGIBILITY

In what was reported in the press as a decision setting a pattern for what claimants may expect to receive under the Cash Sickness Act, Superior Court Judge Patrick P. Curran upheld, on December 5, the contention of the R. I. Unemployment Compensation Board which administers the act, that individuals capable of performing any services for wages are not eligible for cash sickness benefits.

This decision, which is reprinted in its entirety below, resulted from an appealed decision of the Unemployment Compensation Board which, after a hearing last June, sustained a claims examiner and refused to renew the $18 weekly cash sickness payments the claimant had received up to May 5. The worker involved in the case claimed to have received a back injury on November 28, 1944, lifting a bag of cement, and it was his contention that he had not recovered from the injury and being unable to work was entitled to cash sickness benefits. He is receiving workmen's compensation benefits because of the injury.

Counsel for the Unemployment Compensation Board presented its stand that the claimant was able to do some form of work and therefore was not entitled to cash sickness payments.

This court decision brings to the fore again the opinion made by the Rhode Island Medical Society (see R.I.M.J., Vol. 28, No. 2, February, 1945) that the definition of sickness as amended, in the Cash Sickness Compensation Act, presents a conflicting statement. As originally written the definition stated

> "(13) Sickness. An individual shall be deemed to be sick in any week in which, because of his physical or mental condition, he is unable to perform any services for wages."

Then, in 1943, the act was amended by the addition of the following proviso to this definition:

> "PROVIDED, however, that an individual shall be deemed to be sick in any week when such sickness prevents him from being able to perform his regular services, even though such employee is paid his regular wages or parts thereof by his employer for such absence due to sickness."

Judge Curran poses a thought ful question worthy of Assembly review when he asks "What is the meaning of the amendment of this Subsection 13 of Section 2 created by the addition of the amendment of 1943? The conflict between inability *to perform any services* for wages in the original clause and the inability *to perform regular services*, in the proviso, can lend itself to interpretations that may well be far from the intent of the sponsors of the act and of the amendments.

The purchaser of private insurance is entitled to, and can get, a specific and definite explanation of what constitutes disability in his policy. There are three more or less commonly used definitions of total disability in insurance contracts. One is "inability to engage in your own occupation" which would not prevent a beneficiary from earning income in some other way while disabled. Another provides benefits only on "inability to engage in any gainful occupation", which does not mean (as well established by precedent) that the claimant could be forced to engage in a menial task or work with which he is unfamiliar, but which would deny him benefits if he earned a reasonable income from a source other than what might have been his previous regular work. The third definition is that which makes total disability the "inability to engage in any occupation or employment for wage or profit". This is restrictive and lends itself under certain conditions to unfair interpretations, for many disabilities could destroy the ability to continue a regular occupation but would not necessarily render a person unable to perform or engage in some other kind of work.

While the recent court decision will undoubtedly provoke much discussion on the question of eligibility for benefits under the state compulsory program, it would appear that the sickness definition should be rewritten by the General Assembly at the current session to clarify the present misunderstandings.

The decision of Judge Curran follows:

(COPY)

PROVIDENCE SC. SUPERIOR COURT

LORETO SUSI
vs.
UNEMPLOYMENT COMPENSATION BOARD OF R. I.

P. A. 2112

Superior Court
Providence, R. I.
December 5, 1945

JUDGE CURRAN: In this case I find as a fact that the original petitioner, the petitioner Loreto Susi, was until

May 5, 1945, unable, within the meaning of Subdivision 13 of Section 2 of this act, to perform any services for wages and that since that date he has not been able to perform the regular services which he had theretofore performed referred to in the subsection, for consideration, as his regular services, but that he has been able to do other work for which if he could secure it, he would be able to earn compensation-wages. And so I think that squarely raises the question—What is the meaning of the amendment of this Subsection 13 of Section 2 created by the addition of the amendment of 1943?

Now, it seems to me that reading the whole of that additional language, beginning with the words "Provided, however" that the legislature was intending to deprive the Board which passes upon these claims of the right to say that a man has not suffered any loss by reason of his illness and therefore was not entitled to compensation or that he had sustained only a partial loss and was entitled to compensation only commensurate with his loss, or proportionately commensurate with his loss, in view of the amount that he would be entitled to as unemployment compensation.

If the Board, before passage of this amendment, had before it the case where a man was not able to perform his regular work but notwithstanding that was getting his pay in full, he would not be suffering, conceivably, any money loss, and the Board might question, conceivably, there, that he was not entitled to compensation because there was nothing to compensate, he had suffered no loss.

Now the legislature goes along and in 1943, I think, deprives the Board of the right or power to say that and says that when a man is unable to perform his regular services, even though he is paid for his regular services, in whole or in part, he is still entitled to compensation if he is sick, within the original definition of sickness as set out in the first clause of that statute, and the result of that is that when a man is able to perform any compensable services—service for which he can receive compensaion, he is not entitled to compensation of a sick man under the provisions of this act.

I think that the decision of the Board is in accordance with this interpretation of the law. The appeal is denied and dismissed. The appellant may have an exception, and the stenographer will write out this decision in this particular case and a decree may be entered.

ADVERTISING IN STATE MEDICAL JOURNALS

continued from page 29

and they are wrong in the manner in which they have handled the "Cooperative" Medical Advertising Bureau.

A HOSPITAL FOR KENT COUNTY

The Kent County Medical Society has taken forceful leadership with its appointment of a committee to study the question of a hospital which will serve the needs of Kent County, an area which is more or less geographically suited to be a self-sustaining unit from the point of medical care. The population five years ago numbered close to 60,000, and with a strong trend towards suburban housing in the area it is estimated that within the next five years it will increase to 100,000.

The present hospital situation in the State does not adequately begin to solve the medical needs of Kent County. As a result the medical profession in that area has long been concerned with the question of a local hospital, possibly to be located in the vicinity of Greenwood where it would be within a twenty minute auto drive from any point in the county. Such a location would also provide close proximity to Providence where well-trained specialists would be available to staff the hospital adequately with consulting experts.

The location of a hospital in Kent County would in some measure relieve the increasing demand upon the hospitals in the Greater Providence area, and with the Blue Cross Program continually expanding it would appear that an adequate supporting income for maintenance would be available.

With the City of Warwick and the surrounding towns in the County planning war memorials for returning veterans it would appear that no finer tribute could be planned than that each community contribute a unit to a Memorial Kent County Hospital for the improvement of health service to every citizen.

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Receipts

	1944	*1945*
January	$ 331,288.95	$ 275,963.89
February	711,224.16	687,564.82
March	19,737.82	19,300.50
April	497,163.80	363,260.49
May	714,511.59	890,265.89
June	22,871.05	28,901.69
July	536,426.78	394,494.50
August	652,625.83	791,994.00
September	11,774.10	43,096.53
October	419,054.70	376,722.52
November	679,346.34	537,248.22
Total	$4,596,025.12	$4,408,813.05

Benefits

	1944	*1945*
January	$ 288,082.99	$ 336,045.64
February	304,062.08	279,488.25
March	324,997.31	357,327.50
April	347,469.76	373,737.96
May	598,691.00	566,351.00
June	629,753.00	495,147.50
July	521,233.50	468,271.25
August	526,306.25	438,179.50
September	408,754.25	341,409.64
October	409,687.75	374,163.25
November	376,449.87	331,459.75
Total	$4,735,487.76	$4,361,581.24

PATRONIZE

JOURNAL

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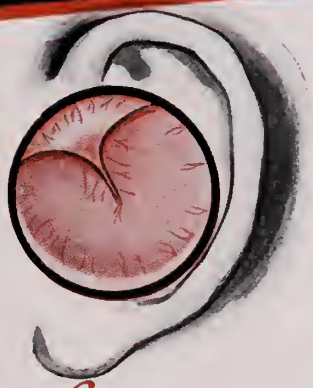
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Treatment

Relief af pain and inflammation—*Auralgan.*

Action

Decongestant, analgesic, bacteriastatic.

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in CHRONIC SUPPURATIVE OTITIS MEDIA

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Persistent discharge, often foul smelling, usually no toxemia, no pain, no fever.

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Formula

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†J. Clin. Investigation 16:547, 1937.

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*J.A.M.A. 123:1007, 1943.

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WELCOME HOME!

The Rhode Island Medical Society reports the following Rhode Island physicians as honorably released from active duty, most of whom have resumed the private practice of medicine in this State as of January 10, 1946. Additional listings will be made each month and members are urged to report promptly upon their return to Rhode Island.

MICHAEL ARCIERO, M.D., 225 Admiral Avenue, Providence

ROBERT R. BALDRIDGE, M.D., 454 Angell Street, Providence

VINCENT A. BIANCHINI, M.D., 1242 Cranston Street, Cranston

GEORGE E. BOWLES, M.D., 155 Thayer Street, Providence

KENNETH BURTON, M.D., 124 Waterman Street, Providence

JARVIS D. CASE, M.D., 28 Hoxsie Court, Phoenix

SAMUEL D. CLARK, M.D., 366 Hope Street, Bristol

GEORGE F. CONDE, M.D., 137 Academy Avenue, Providence

FRANK B. CUTTS, M.D., 124 Waterman Street, Providence

ERIC DENHOFF, M.D., 187 Waterman Street, Providence

PALMINO DiPIPPO, M.D., 1536 Westminster Street, Providence

ROBERT W. DREW, M.D., 391 Main Street, Warren

JOHN S. DZIOB, M.D., 200 Olney Street, Providence

PETER C. ERINAKES, M.D., 119 Washington Street, West Warwick

JOSEPH C. FLYNN, M.D., 559 Cranston Street, Providence

DAVID FREEDMAN, M.D., 224 Thayer Street, Providence

SOLOMON L. FRUMSON, M.D., Monument Square, Woonsocket

JOHN A. GORMLY, M.D., 187 Academy Avenue, Providence

JAMES P. HEALY, M.D., Fanning Building, Pawtucket

KIERAN W. HENNESSEY, M.D., 520 East Avenue, Pawtucket

WILLIAM V. HINDLE, M.D., 655 Broad Street, Providence

HUBERT HOLDSWORTH, M.D., 225 Hope Street, Bristol

JOHN D. HUBBARD, M.D., 162 Angell Street, Providence

WILLIAM N. HUGHES, M.D., 112 Waterman Street, Providence

GEORGE A. KEEGAN, M.D., 34 Hamlet Avenue, Woonsocket

HUGH E. KIENE, M.D., Charles V. Chapin Hospital

HERMAN A. LAWSON, M.D., 454 Angell Street, Providence

FRANK B. LITTLEFIELD, M.D., 143 Bayard Street, Providence

JAMES P. LONDERGAN, M.D., 81 Governor Street, Providence

HERMAN B. MARKS, M.D., 48 Blaisdell Avenue, Pawtucket

AMEDEO MASTROBUONO, M.D., Exeter School, Box 83, Lafayette

JOHN A. MELLONE, M.D., 15 Bay Spring Avenue, West Barrington

EDWARD G. MELVIN, M.D., 369 Broad Street, Providence

WHITMAN MERRILL, M.D., Washington

CECIL J. METCALF, M.D., 150 Norwood Avenue, Edgewood

JAMES B. MORAN, M.D., 389 River Avenue, Providence

ROBERT G. MURPHY, M.D., 184 Angell Street, Providence

THOMAS A. NESTOR, M.D., 97 East Manning Street, Providence

FRANCIS NEVITT, M.D., 659 Hope Street, Providence

RODRIGO P. D. C. REGO, M.D., 103 Governor Street, Providence

CLARENCE RILEY, M.D., 507 Manton Avenue, Providence

FREDERICK R. RILEY, M.D., 1264 Elmwood Avenue, Providence

NATHANIEL D. ROBINSON, M.D., 130 Wayland Avenue, Cranston

EDWARD F. RUHMANN, M.D., 1711 Broad Street, Cranston

JOSEPH RUISI, M.D., 41½ Grove Avenue, Westerly

BERNARD SELTZER, M.D., 300 Pontiac Avenue, Cranston

BENJAMIN S. SHARP, M.D., 339 Thayer Street, Providence

H. FREDERICK STEPHENS, M.D., 195 Thayer Street, Providence

GEORGE L. WADSWORTH, M.D., State Hospital, Howard

GUY W. WELLS, M.D., 124 Waterman Street, Providence

SAUL WITTES, M.D., 211 Stadium Building, Monument Square, Woonsocket

EDWIN VIEIRA, M.D., 221 Warren Avenue, East Providence

MILITARY ANNOUNCEMENTS

TRANSFERS:

LT. THOMAS L. O'CONNELL, MC, 318763, Base Hospital 15, Navy 3205, c/o FPO, San Francisco, Calif.

LT. JOHN R. CRANOR, JR., USNR, Office of Naval Officer Procurement, 617 Vine Street, Cincinnati 2, Ohio

CAPT. EMIL A. KASKIW, MC, Kennedy General Hospital, SCU 1489, Sta. Com., Memphis, Tenn.

CAPT. JOHN A. DILLON, MC, 0-426505, Waltham Regional Hospital, Waltham, Massachusetts

MAJOR WALTER E. BATCHELDER, 01696252, Med. Sec., Pers. Ctr., Fort McPherson, Georgia

LT. FRANCIS E. HANLEY, MC, 426159, G10, NR81, Navy 3002, c/o FPO, San Francisco, California

CAPT. WERNER SEGALL, 427 W. Mistletoe, San Antonio, Texas

CAPT. I. GERSHMAN, 047535, 312th Station Hospital, APO 413, c/o PM, New York, New York

LT. (J.G.) A. L. LAGERQUIST, MC, USNR, U.S.S. Lindenwald (LSD-6), FPO, San Francisco, Calif.

CAPT. GEORGE M. VIAN, MC, 0-1696234, Med. Det. 738, MP Bn., APO 75, c/o PM, San Francisco, Calif.

LT. ROBERT W. RIEMER, MC, 0-925892, 116 General Hosp., APO 403, c/o PM, New York, N. Y.

CAPT. J. SAVRAN, MC, Regional Hospital, Fort McClellan, Alabama

PROMOTIONS:

COMMANDER WILLIAM N. HUGHES to Captain

MAJOR JOHN A. MELLONE to Lt. Col.

THE COMPULSORY PROPOSAL . . . .

How Can We Assure Adequate Health Service for All The People?

(Abstracts from an address by Arthur J. Altmeyer, Chairman, Social Security Board, at the First Annual Conference of Presidents and other Officers of State Medical Societies, sponsored jointly by the California Medical Association and the Michigan State Medical Society, at Chicago, December 2, 1945)

At the outset, may I state plainly my opinion that there is no disagreement among us in our desire and determination that everybody, regardless of financial circumstances, shall be able to have adequate health services—meaning essential services of good quality. None of us wants to see anybody suffer or die for lack of medical care.

I believe also that the standards of good medical practice and of good hospital care in this country are probably second to none in the world today. The medical profession and hospital administrators have a right to be proud of the great progress these standards represent.

It is also true that, with few exceptions, the death rate in this country has declined year after year, particularly since the turn of the century. In 1900 there were 17 or 18 deaths per thousand of population, as compared with 11 per thousand in 1940. This is indeed notable progress.

Since all this is true, it may be asked "Why is it necessary to embark on a national health program?" And, especially, "Why is it necessary for the Government to assume major responsibility?"

The answer is twofold. In the first place, while we have made notable progress in reducing the death rate in this country, we are not the healthiest nation in the world. In the second place, while we have achieved high standards in medical and hospital care, this high-quality care is not within the actual reach of large numbers of our people. Putting it bluntly, there are many Americans this very minute who are suffering and dying needlessly for lack of medical care.

The statement has been made many times that we are the healthiest nation on earth, but statistics for the years just preceding the war show conclusively that we are not. Probably the best single measure of our relative health status is the infant mortality rate. In terms of this index, we stood seventh. Moreover, the comparisons in general were increasingly unfavorable to us as we proceeded from the death rates for infants to those of older groups of our population.

* * *

In addition, we should not draw too much satisfaction from the fact that our death rate has declined markedly since the turn of the century. We should not forget that about 70 percent of the reduction was made by 1920 and almost all of it by 1930. We must also remember that the major part of the reduction in death rates has been due largely or almost wholly to the reduction in deaths from infectious diseases that are susceptible of mass control. If we are to have anything like a similar improvement in death rates in the future, we must not only expand our efforts in the mass control of infectious diseases but also assure more nearly universal access to individual medical care of noninfectious diseases.

What should concern us more than comparisons with other nations or with former years is the fact that we have done much better in protecting health in some places than in others, for some types of diseases than for others, and for some groups of the population than for others. The real measure of our past accomplishments and of our future opportunities is what we can do with our available knowledge. (As this group well knows in many parts of the country and among many groups of our people, death rates are far higher than they need be.)

* * *

Infant mortality illustrates similar wide differences among the States. In 1943, the State with the lowest infant mortality reported 29 deaths per thousand live births; the State with the highest mortality had more than 3 times that rate. In some half-dozen States with the highest infant death rates, at least half the babies who died could have been saved had they been fortunate enough to have been born in areas where conditions were more favorable for their survival.

In this connection, the relationship between infant mortality and medical attendance at birth deserves mention. In the 10 States with lowest infant mortality in 1942, 88 percent of the births in that year took place in hospitals and less than 1 percent of the births lacked medical attendance. In contrast, in the 10 States with the highest infant mortality, only 47 percent of the births were in hospitals, and 12 percent had no medical attendance.

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THE VOLUNTARY WAY . . . .

Expansion of Volutary Group Health Care Programs

(Abstracts from an address by Joseph H. Howard, M.D., President of the Connecticut State Medical Society, at the First Annual Conference of Presidents and other Officers of State Medical Societies, sponsored jointly by the California Medical Association and the Michigan State Medical Society, at Chicago, December 2, 1945)

CLEARLY, the time for argument has almost run out. The time for action is here, and those who know what the evils of compulsory insurance would be must be prepared to meet constructively the benefits which are sought, through a comprehensive medical care program on a national basis.

There is an axiom of politics which the late Al Smith used to quote even though he may not have been the originator of it, and it said: "You can't beat somebody with nobody."

It is not my function at this time to marshal the arguments against Government control of the care of private health. Those arguments are impressive, but we must realize that a need exists for better provision for building the national health, and it is up to the medical profession to take the leadership in doing it or to surrender the responsibility to those in whose hands we would not like to see it placed.

"States' Rights" has been an issue in the political life of our country ever since it was founded. Great leaders have joined the issue on this question, but our own Governor Baldwin of Connecticut and other fore-sighted leaders of poltical and economic thought have said that the only way that states' rights can be maintained as against the ever-increasing power of the Federal Government and its incursion into the lives of all of the people, is by meeting the needs of our people promptly and better than can be done by the National Government.

We have seen many of the things that Federal control can do to our daily lives, in the effect of the regulations under which we worked during the war just closed. We can observe the efforts of the ardent advocates of a more powerful Federal Government in many phases of our daily lives,— the efforts to federalize education, the efforts to federalize all hiring and firing, the "ceilings" on prices, wages, and, in fact, almost everything that effects our daily lives.

President Truman, in his historic report on his conference with the heads of the other great powers at Potsdam, stated, "The war has shown us that we have tremendous resources to make all the materials of war. It has shown us that we have skillful workers, managers, and able generals, and a brave people capable of bearing arms. The new thing, the thing we have not known, the thing we have learned now and are never forgetting is this —that a society of self-governing men is more powerful, more enduring, more creative, than any other kind of society, however disciplined, however centralized. We know now the basic proposition of the work and dignity of man is not a sentimental aspiration or a vain hope or a piece of rhetoric. It is the strongest and most creative force now present in this world."

This does not sound like the same Mr. Truman who gave us the socialized medical program of last week.

On the very day that President Truman sent his message concerning a National health program to Congress, Senator Wagner, in introducing the new Bill, accompanied his remarks by a statement which he inserted in the Congressional Record, purporting to give the "answers" to questions which had been raised or would be raised about the prepaid medical care provisions of his proposed "National Health Act of 1945," and to the question about "socialized medicine," Senator Wagner said, "The bill does not provide for 'socialized medicine' if by the term is meant medical care furnished by government doctors, free of charge."

You will see that this is a very narrow definition, and you will see further by an examination of the bill, that *is* socialized medicine.

Yet, the President has taken the words of Senator Wagner and said, "This is not socialized medicine. We do not want socialized medicine."

Well, it is federalized medicine, and this nation has had some rather unpleasant experience with federalized medicine during the war, with some of the medical programs carried out under the Children's Bureau which were claimed to be merely emergency measures that would be required only during the war, but they would still be carried on after the war under the so-called Pepper Bill. If such a program is given to us as non-socialized medicine, you can be sure that it is inevitably a step towards socialized medicine, if the doctors agree to the present program.

Under the cloak of the favorite expression, "free choice of physicians," the bill covers some danger-

continued on page 49



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sample size

THE COMPULSORY PROPOSAL

continued from page 37

The Financial Barrier to Adequate Medical Care

The availability or absence of medical care is not the only reason for these and other differences in the security of life in the United States. Differences in economic circumstances, and consequently in housing and living conditions, no doubt contribute to the differences in death rates. No economic factors, however, are as significant as the availability of public and individual provision of health and medical services.

It is still commonly said that the poor and the rich get the best care. This oft-repeated generalization has caused much confusion. The fact is that poor people have more illness and have higher death rate than the well-to-do, but they receive far less medical care per family and per case of sickness. Poverty, illness, and inadequate medical care go together. The National Health Survey, conducted by the United States Public Health Service in the winter of 1935-36, showed that there were 2½ times as many days of disability among persons on relief as among those having a family income of $3,000 or more. The number of days lost by persons not on relief but with a family income of less than $1,000 was twice that experienced by those with a family income of $3,000 or more.

This Survey also showed that while there was much more serious disability among those with the least income, a substantially larger proportion among them than among those in the higher income brackets failed to receive any medical attention whatsoever.

* * *

Government Responsibility for Meeting Health Needs

If we agree that nobody should suffer or die for lack of access to medical care, do we not have an obligation to break down the financial barriers between sick people and their doctors and hospitals? Is a democratic government meeting its full responsibility if the primary essential of human existence—the health of the people—is not safeguarded and improved to the utmost extent that medical science and our resources make possible?

That this is an accepted responsibility of government is recognized by the fact that our government has already gone a considerable distance in protecting and promoting the health of the people. In addition to public sanitation and public health services, we have provided public medical services for the indigent, though with widely varying degrees of adequacy in different localities. Nor has governmental assistance for medical care been limited to indigents. In 1944, 85 percent of all the beds in tuberculosis hospitals were in government-operated institutions. Hospitalization for persons afflicted with nervous and mental disease has become almost exclusively a government function, and this hospitalization has by no means been limited to the indigent.

Even in the field of general hospital care the role of government has become increasingly important. In addition to the hospitals for veterans and other wards of the Federal Government, about 28 percent of all the beds in general and special hospitals are in government-owned institutions.

Through workmen's compensation laws, the State governments and the Federal Government have assured medical services for work-connected accidents and diseases.

Of course the Federal Government has always been responsible for the medical services of the armed forces . In addition, it has provided hospital and medical care for merchant seamen for a century and a half. For more than a quarter of a century special provision has been made to assure hospital and medical care for veterans. This activity is destined to grow by leaps and bounds. Thus, it is estimated that in the next 30 to 40 years the government will be providing hospital and medical care for 15 to 20 million veterans.

Under the Social Security Act, the Federal Government has made grants-in-aid to States for maternal and child health services, services to cripple children, and State and local public health services. It also has been providing funds for the control of venereal diseases.

Since 1942 the Federal Government has been paying for the maternity and infancy care of the wives and infants of servicemen. During the last fiscal year the expenditures under this program alone amounted to $45 million.

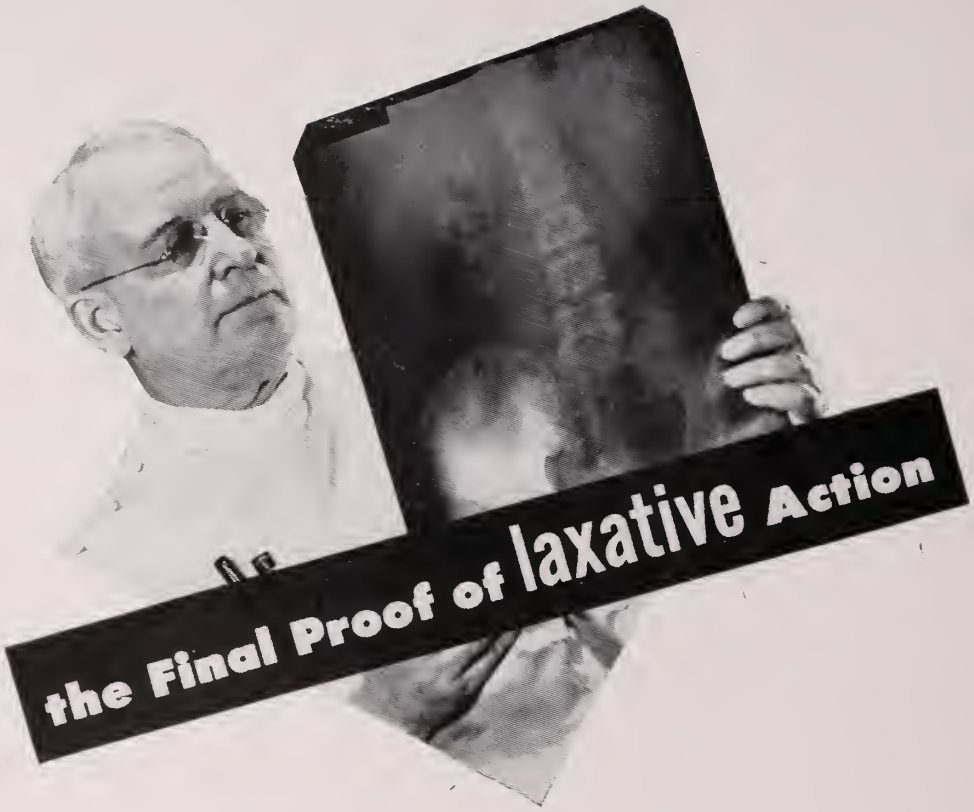
Last year the new Public Health Service Act became law, increasing the financial support for public health and for research and authorizing a new, large-scale attack on tuberculosis. All-in-all, in 1944 governmental expenditures — Federal, State, and local — for public health and medical services, exclusive of medical care for the armed forces, totaled nearly a billion dollars, or one-fifth of all the expenditures for health and medical care in the United States.

Thus it is apparent that the question before us is not whether the government should assume responsibility for protecting and promoting the health of the people, but rather how much further the government should go in meeting that responsibility.

President Truman's Health Message

The President of the United States has placed his views before the Congress in his Message of

continued on page 43



Roentgenographic studies after barium meals may do much to *qualify* a laxative for your further consideration. For your inspection, excellent visual records are available in support of EMODEX. Nevertheless, every physician knows that such studies are not the final proof of laxative action. *The final proof lies in your own experience.* On request, you will receive a free, full-size trade package of EMODEX for trial in your practice.

Each EMODEX tablet contains aloin 1/12 gr., extract cascara sagrada 1⅔ gr., extract rhubarb 1⅓ gr. and phenolphthalein ⅓ gr. with excipients and coating. It is *indicated* in habitual or chronic colon constipation.

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for colonic constipation

DOSAGE: *Adults:* 3 tablets with water at bedtime. *Older children:* 1 or 2 tablets. Caution—any laxative is contraindicated if symptoms of appendicitis or intestinal obstruction are present.

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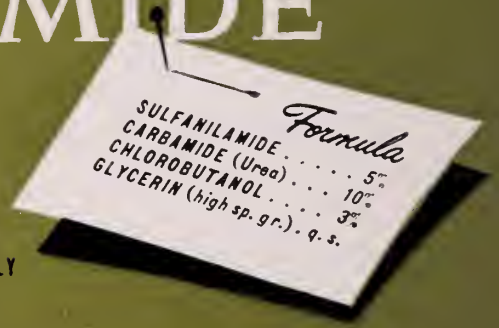
ANALGESIA—effective chlorobutanol analgesia without impaired sulfonamide activity.

1. Tsuchiya, H. M. et al.: Proc. Soc. Exp. Biol. and Med., *50*:262, 1942.
2. Strakosch, E. A. and Clark, W. G.: Minn. Med. *26*:276, 1943. Brown, C. et al.: Am. J. Surg., to be published.



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THE COMPULSORY PROPOSAL

continued from page 39

November 19, in which he outlined a national health program. . . . I shall discuss only the proposal for a Nationwide system of health insurance, since that is the most controversial and is probably of the greatest concern to practicing physicians.

The question is whether it is still necessary for the government to take some action to spread the cost of medical care for self-supporting individual families if it does these other things, concerning which there is more or less general agreement. That is to say, would it be enough if the Federal Government expands its public health and maternal and child health programs, makes certain that hospitals, health centers, clinics and diagnostic facilities are available in every part of the country, and finances the cost of providing care of the indigent? If all that is done, why cannot the normally self-supporting families be expected to pay for their own medical care either directly or through voluntary insurance plans of one kind or another? These are questions that deserve careful consideration.

* * *

If sickness were predictable and if it affected families equally, the problem of paying for needed medical services would be less serious. But, as we al know, sickness costs often come suddenly, unexpectedly, and in large amounts. One illness may involve a cost of only a few dollars and another illness may require more than the family income for weeks, months, or even years. No one knows when an illness may strike or how much it will cost.

Spreading the Cost of Medical Care

The only way most of the American people can meet this problem is by spreading the cost of medical care over sufficiently long periods of time and among large enough groups of persons so that the cost will not be unbearable in the individual case. If this were done, and the average amount were adjusted according to income, the cost of adequate care would not be unbearable even for persons with relatively small incomes.

* * *

If the problem is to spread the cost of medical care, the question remains why can't we rely on the individual to obtain his own insurance? Hard facts spell the answer. The poor cannot afford to pay the full insurance premium. Most of those who are normally self-supporting have immediate wants which press on them to the exclusion of protection against future possible costs that may not actually occur. In other words, our day-to-day wants and necessities induce us to take a chance.

* * *

It is possible that, altogether, about 40 million persons have *some* voluntary protection against the costs of hospitalization or medical services. While this protection is significant, the available figures indicate that voluntary insurance alone does not assure adequate protection for most Americans against the cost of medical care. Moreover, when we consider the economic status of those who now have such protection and of those who do not have it—but do experience more frequent and serious illnesses—it becomes all the more evident that voluntary insurance is not a complete or adequate answer to this national problem of spreading the costs of medical care.

Distinction Between "State Medicine" and Health Insurance

There are two possible ways in which the government can undertake to spread the cost of medical care. One is through providing medical care free of charge to the recipient, financing it through general taxation. The other way is through a system of health insurance, financed largely through contributions by potential beneficiaries and their employers. Under the first approach, medical care would be provided just as education is now provided. The practitioners would probably be for the most part salaried officials employed by the agency of government providing the medical services. Such a system is usually termed "state medicine" and sometimes "socialized medicine." However, these terms are so indefinite and confused that they are sometimes used to cover not only public sanitation, public health services, and medical services provided by government for specific groups in the population, but also health insurance.

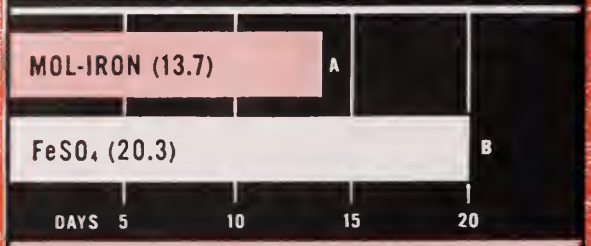
It is essential for clear thinking that the distinction between state medicine and health insurance be kept in mind. State medicine implies medical services provided by physicians employed by the government; health insurance, on the other hand, implies a system whereby medical service is provided by private, competitive practitioners who are reimbursed from a special insurance fund for the services they render. In other words, state medicine is not only a system for spreading the cost of medical care but also a system of medical practice; in contrast, health insurance is a system for spreading the cost of medical care and does not replace the competitive private practice of medicine. Only the Union of Soviet Socialist Republics has a national system of state medicine; more than thirty countries have national system of compulsory health insurance.

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A NEW AND DEFINITE ADVANCE IN TREATING IRON-DEFICIENCY ANEMIAS

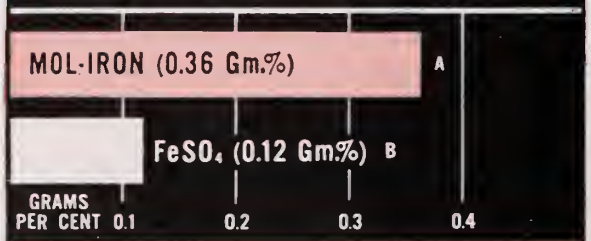
Rapidity of Clinical Response



(A) Completely effective therapeutic response (return to normal blood values) was obtained in an average of 13.7 days of Mol-Iron therapy.

(B) Ferrous sulfate therapy *failed* to produce normal hemoglobin values after an average of 20.3 days.

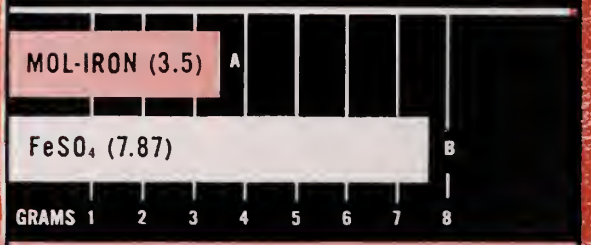
Average Daily Hemoglobin Increase



(A) The group treated with Mol-Iron averaged a daily hemoglobin increase of 2.48 per cent (0.36 Gm. per cent).

(B) The group treated with ferrous sulfate showed an average daily gain of hemoglobin of 0.83 per cent (0.12 Gm. per cent)—a response about one-third as effective.)

Therapeutic Intake of Bivalent Iron



(A) The Mol-Iron treated group received an average total of 3.528 Gms. of bivalent iron to produce the sought for result (return to normal blood values).

(B) While an average ingestion of 7.871 Gms. of bivalent iron failed to achieve an optimal response in the ferrous sulfate treated group.

The charts summarize the results of a controlled study of comparative therapeutic response in post-hemorrhagic and nutritional hypochromic anemias.

The series includes 49 cases treated with Mol-Iron and 21 with exsiccated ferrous sulfate; the results are typical of those observed in treatment of iron-deficiency anemias with White's Mol-Iron.

A specially processed, co-precipitated complex of molybdenum oxide (3 mg.) and ferrous sulfate (195 mg.).

White's MOL-IRON TABLETS

Available clinical evidence indicates that, in hypochromic anemia, the therapeutic response to this highly effective synergistic combination—as compared with equivalent dosage of ferrous sulfate alone—has unusual advantages:

1. NORMAL HEMOGLOBIN VALUES ARE RESTORED MORE RAPIDLY, INCREASES IN THE RATE OF HEMOGLOBIN FORMATION BEING AS GREAT AS 100% OR MORE IN PATIENTS STUDIED.
2. IRON UTILIZATION IS SIMILARLY MORE COMPLETE.
3. GASTRO-INTESTINAL TOLERANCE IS NOTABLY SATISFACTORY—even among patients who have previously shown marked gastro-intestinal reactions following oral administration of other iron preparations.

INDICATED IN:

Hypochromic (iron deficiency) anemias caused by inadequate dietary intake or impaired intestinal absorption of iron; excessive utilization of iron, as in pregnancy and lactation; chronic hemorrhage.

DOSAGE: One or two tablets three times daily after meals.

Available in bottles of 100 and 1000 tablets.

Ethically promoted—not advertised to the laity.

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THE COMPULSORY PROPOSAL

continued from page 43

It would be possible to have a system of health insurance on a strictly state-by-state basis, like workmen's compensation, without any assistance from the Federal Government. Or it would be possible for Congress to enact legislation which would create a strong inducement for the States to enact such laws, as was done in the case of unemployment compensation. Or it would be possible for Congress to enact a wholly Federal health insurance law.

Decentralization of Administration

If Congress enacted a wholly Federal health insurance law, it would still be possible to allow for State administration. Contributions to finance the health services could be collected along with the contributions made under the Federal old-age and survivors insurance system without any additional inconvenience to employees or employers, and without additional cost to the Government. The added cost of administering health insurance as part of a unified social insurance system probably would not exceed 5 percent of the total cost of benefits provided.

Free Choice for Patient and Doctor

The administration of the benefits should be decentralized so that all necessary arrangements with doctors and hospitals and public health authorities could be subject to adjustment on a local basis. The local hospitals and doctors should be permitted to choose the method of remuneration which they desire. The method of remunerating hospitals could be on a fixed per diem basis regardless of the cost of the service to the hospital or the patient, or it could be on the basis of the actual cost of the service to the hospital—within fixed minimum and maximum limits, or it could be a combination of the two methods. The payment of doctors could be on the basis of fee for services rendered or a per capita fee per annum, or straight salary—part-time or full-time—or it could be some combination of these arrangements.

Besides free choice of method of remuneration, the system should provide, of course, free choice of physicians and free choice of patients. The professional organizations themselves should be relied upon to assist in the maintenance and promotion of desirable professional standards.

* * *

Utilization of Voluntary Organizations

Voluntary organizations that provide health services would have an important role under a system of health insurance. So would voluntary cooperative organizations that are concerned with paying doctors, hospitals, or others for health services but do not provide these services directly. Specifically, medical society plans that provide services directly or pay for services rendered could play an important part in simplifying administration, promoting desirable professional relations, and furnishing—or arranging to furnish—adequate medical care promptly and efficiently.

* * *

Under a system of health insurance, the government could make arrangements to deal with the voluntary groups that furnish health services directly or pay for services rendered. The simplest arrangement would be for the government to reimburse the organization either on an individual patient or service basis, or on an estimated total cost basis, having regard for the number of insured persons that it serves. Such a relationship would involve a minimum of control by the Government and a maximum degree of independence on the part of the group and the members composing the group.

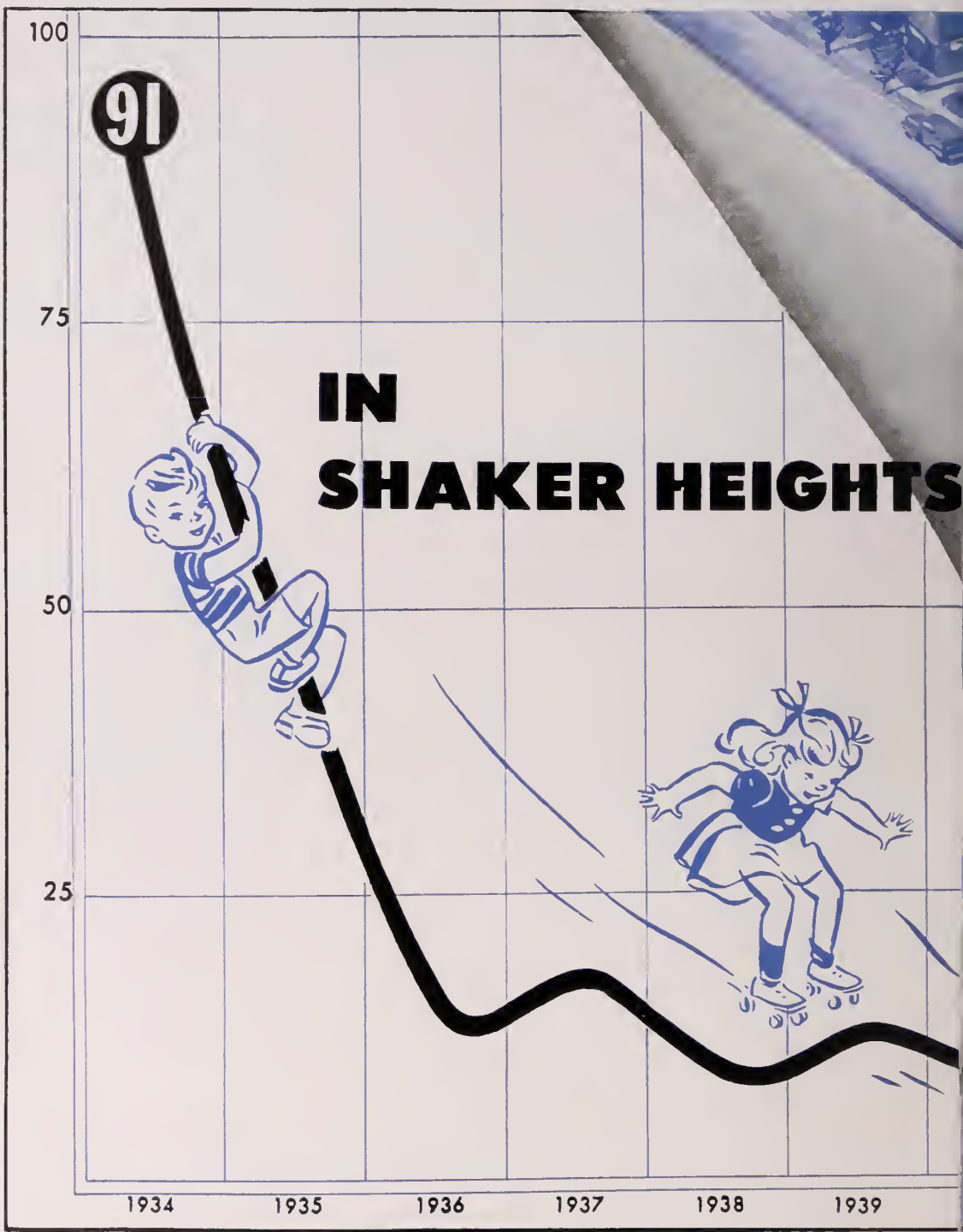
* * *

By and large, it seems to me that quality of care should improve rather than decline if payment for service is guaranteed. It is alleged, however, that other characteristic of an insurance system will dominate the picture. And one hears about "regimentation" of doctors, "assignment of patients," "political control," etc.

We are agreed, I believe, that the patient shall have free choice of doctor, and that the doctor shall be free to accept or reject patients. If the fee no longer stands between patient and doctor, the competitive relation between doctors will still remain, but it will rest on quality and adequacy of care. These are essentials for continuing good care. Where then are the issues?

One question concerns control over the professional aspects of medical practice. This is an ancient question—older than the Hippocratic Oath. The guidance, the direction, the supervision, the discipline of doctors are primarily matters for doctors to handle. Subject to Government regulation through licensure, the responsibility has always been yours and should remain yours. No Government officer in his senses would take any other position. Just as public licensure gave the profession a new opportunity to deal with these problems, just as grading of medical schools, registration of hospitals, administration of workmen's compensation, and establishment of voluntary insurance plans—to mention only a few—gave you new opportunities to exercise professional controls, so inauguration of health insurance gives you still another in the long evolutionary movement for high ethical and qualitative standards. On this broad

continued on page 55



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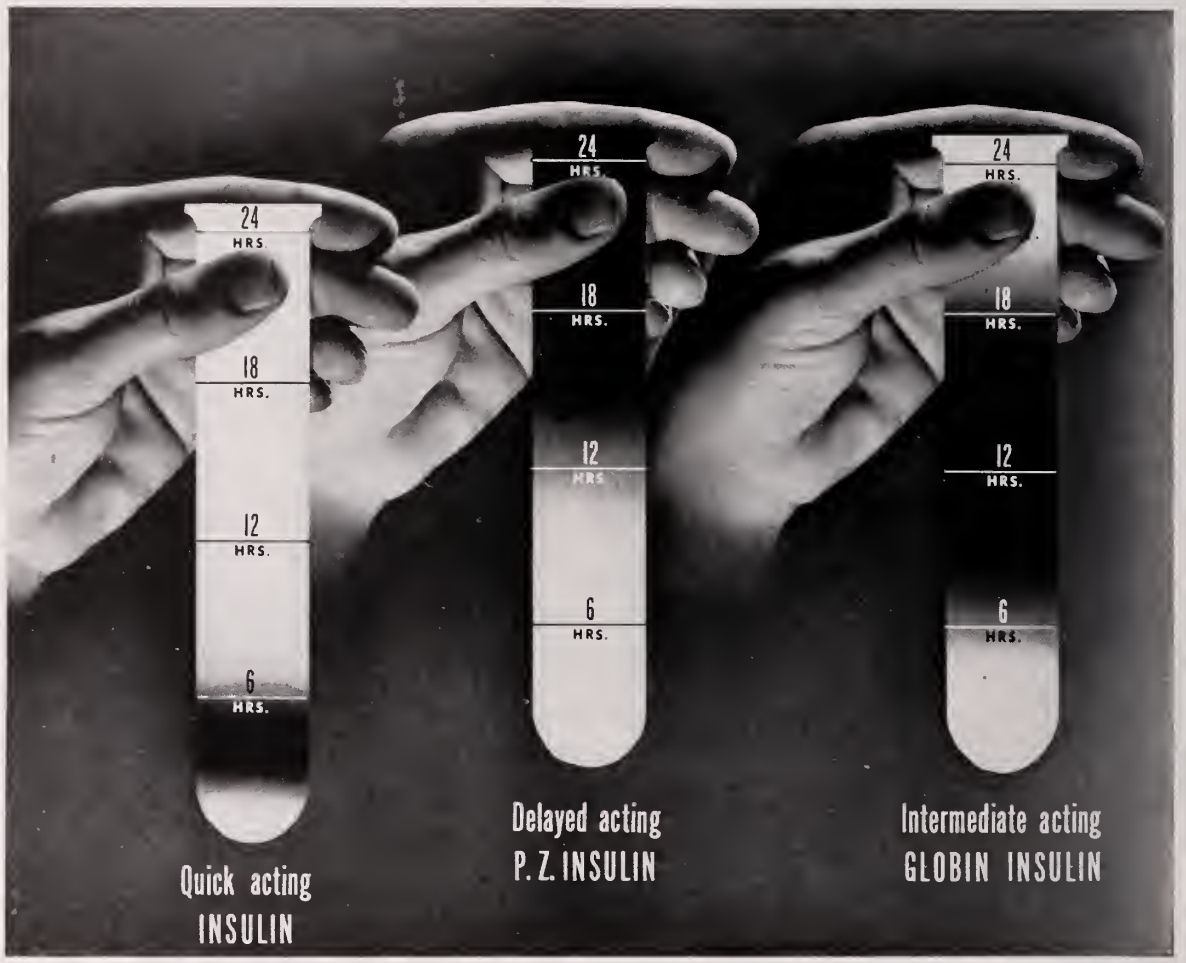


Nine years' routine immunization of Shaker Heights children of pre-school age against whooping cough, using Sauer's vaccine, has cut the annual incidence of pertussis in this age group from 91 to a yearly average of 6 during a 4-year period . . . and the six who contracted the disease in 1943 were children *who had not been immunized.*[1]

[1] Garvin, J. A., Ohio State M. J. 41:229, 1945.

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Evolution of the 3rd insulin . . .



A NEW type of insulin is available for the diabetic —Globin Insulin. First there was a quick-acting but short-lived form. Next came a slow-acting but prolonged type. Now there is the intermediate-acting 'Wellcome' Globin Insulin with Zinc. Activity begins with moderate promptness yet it continues for sixteen or more hours, sufficient to cover the periods of maximum carbohydrate intake. Activity diminishes by night so that nocturnal reactions are minimal.

A single injection daily of 'Wellcome' Globin Insulin with Zinc controls the hyperglycemia of many patients. Physicians are rapidly learning to take advantage of this new third form of insulin when prescribing for their patients.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc. and vials of 10 cc., 40 units in 1 cc. Literature on request. 'Wellcome' trademark registered.

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THE VOLUNTARY WAY

continued from page 37

ous provisions and developments. By the use of this expression, the people, it would appear, will think that when this bill is passed, they can call their own doctor any time to be taken care of; but they do not tell us in this bill that the "free choice of physicians" includes only those physicians who are participating in the program. Therefore, if a family has a particular family doctor, and he does not participate in the plan, that family still will pay its taxes under this bill, but they will have to call the family doctor and pay him if they want him.

Another significant thing about the bill and about the discussion of it by its porponents is that the real cost of the measure is not made clear. Nowhere in the bill is the term "taxes" or "taxation" used. The proponents tell us that this is a "contribution" and not "taxation" of the worker to this particular program. Therefore, by using the term "contribution" and not "taxation" it will include all those non-taxable people who previously had a free choice as to payment for medical care.

* * *

The way to combat this federalization of medicine is by the development of voluntary plans in the various states. During the legislative session of 1945 more than thirty bills proposing cash sickness benefit plans, or compulsory health insurance systems were introduced in twelve state legislatures. Other bills called for studies of health insurance.

Under the compulsory type of insurance, of course, everybody would be required to pay taxes regardless of whether or not he sought medical care. Peculiarily enough, the greatest demand for compulsory health insurance comes from those states which were best supplied by hospitals and physicians. For instance, in New York state there were twenty-seven health insurance bills introduced in the assembly between 1935 and 1945. Yet New York has far better medical and hospital facilities than the average state. On the other hand, the Southern states such as Mississippi, Alabama, and others, where the need for medical care is most acute, have practically no organized demand for compulsory health insurance. One may wonder what, then is the reason for this movement in New York and other states for a compulsory health insurance bill.

The most powerful single force which is promoting the demand for compulsory health insurance is organized labor. The time most conducive for this demand is a period of depression. The place of such demand is the large industrial center where employment may have declined and where earnings may be low.

The need for improved medical care, particularly in some areas of this country, may be conceded and need not be argued. The form that this program should take is what is in question, also the administration of it, the benefits, and other details. Comprehensive statistics on the extent and prevalence of disease in the various states have not been obtained. Therefore, a complete study should be made first.

In considering any national health program, we must think of three major points: First, the need for supplying medical care and hospital service where none now exists; Second, the need for better sanitation and hygiene; Third, the need for economic development and improvement of the working conditions of the people, which will help to overcome some of the deficiencies which lead to disease.

All these points above are approved by the American Medical Association, the first as included in the Hill-Burton Bill, the medical profession is in back of it. Concerning the second point, this is a public health measure which should be developed by local communities with the aid of states and of the United States Public Health Service. The third point involves an expanding of our national economy, which can be accomplished only by less federal control and the encouragement of free enterprise.

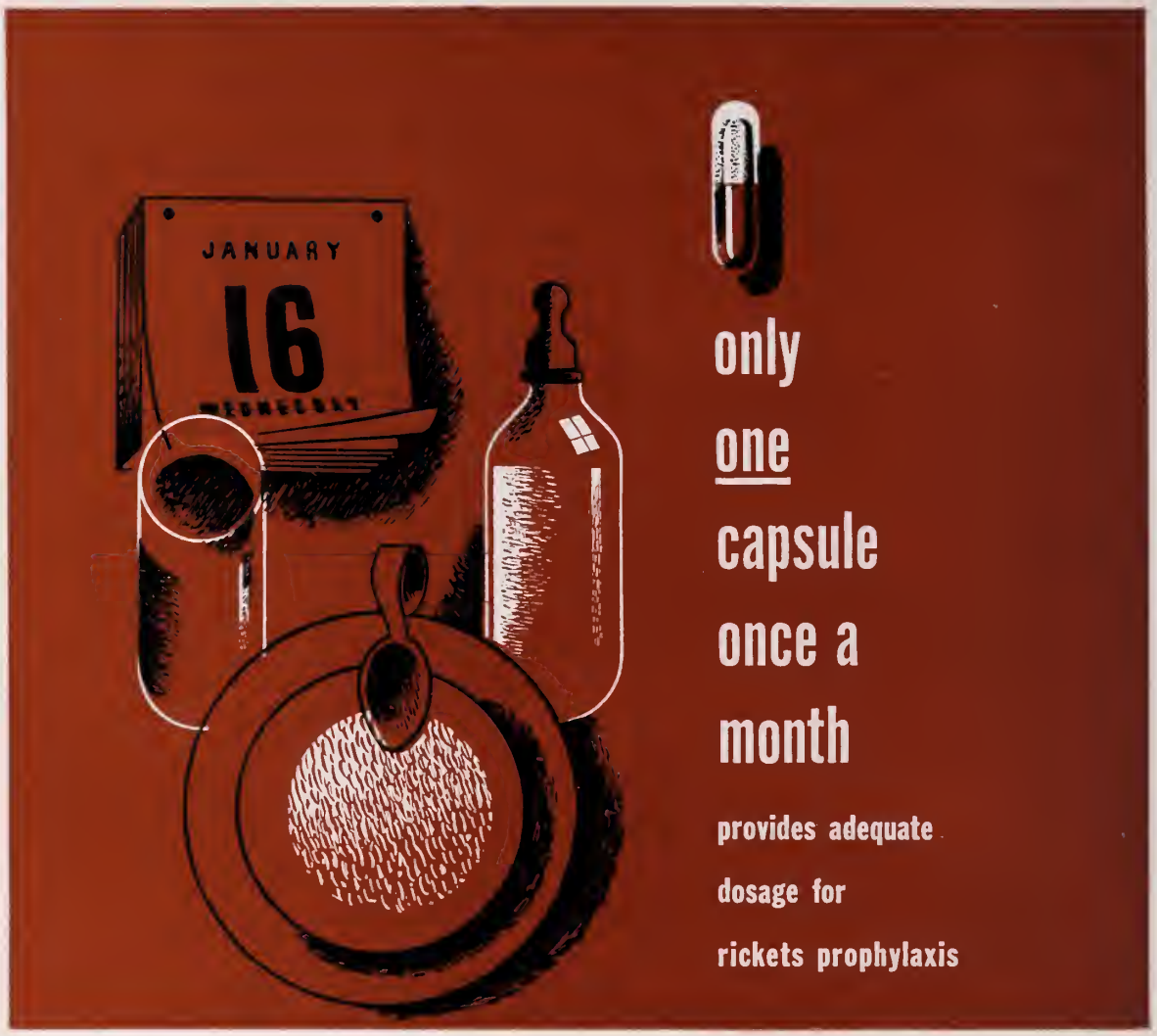
In accepting the responsibility for meeting the needs of our country for improved health and better financing of medical care, medical leaders must have certain well-defined and unified objectives, and the following are proposed for your consideration:

Establish statewide, voluntary, non-profit health care programs in every state, based on the free choice of purveyor of health care. Such programs will vary in each state depending upon the type of policy written. For example, an indemnity plan for those classified as above the income level by each state or regional unit, and a service plan for the indigent and low income families by contractual arrangement for payment of charges by the county, state, or federal government; a service plan for all other governmental categories eligible for health care; a service plan for all physicians' services to veterans of the armed forces for all illnesses and disabilities eligible under the law. Any further federal or state programs for expansion of medical service may be developed within the structure of the program described here.

* * *

Financial responsibility for the care of the indigent tradtionally has been a government function, and this must remain with government. Gov-

continued on page 51



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Infron Pediatric is readily miscible in the infant's feeding formula, milk, fruit juices, or water, and can also be spread on cereal.

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THE VOLUNTARY WAY

continued from page 49

ernment and the medical profession must undertake a program for the more effective cooperating arrangement in the field of health, so that the indigent may have the same free choice of Doctors of Medicine and hospitals as the self-supporting.

This complex problem is made simple by the professionally administered group health care program. Incidentally, use of such a program calls for the adoption of a uniform fee schedule which puts an end to the unfair practice of forcing physicians to accept a fifty per cent discount for the care of government wards.

The new philosophy is—"in the light of modern conditions, changes, and trends, and the creation of new groups and categories—since in the past the medical profession has sold its commodity of service to government agencies at less than cost,"—that the minimal fee in the future shall be commensurate with the work done."

The time is here to withdraw the philosophy of a special discount rate to government for care of wards of government.

Another greatly increasing category, the wards of government, including veterans, rehabilitated persons, crippled persons, etc., will all gain better health care from a cooperative arrangement between government and the medical profession. The extension of the facilities of the Doctors' voluntary, prepayment health care projects, and the recent reorganization of the Veterans Administration, bring hopeful signs that such cooperation will be more than wishful thinking. The home and office medical care and emergency hospitalization of veterans by private practice of medicine, that is the use of the physician-patient relationship, may be a boon to the veterans.

There is no doubt about it, the American people want security against unpredictable financial loss due to ill health and injuries. At this point, many do not seem to know that there are alternatives to Government action to far as provision for medical care with a convenient method of payment are concerned. That is because a part of the medical profession has not assumed its full responsibility in developing and advancing the voluntary program.

The development of voluntary medical care programs and the experience under these various programs can be consolidated to offer the right answer to the compulsory medical care program as advocated by President Truman.

Voluntary medical care programs are sponsored by state and county medical societies, and are increasing every day. There are more than forty bureaus for executing such programs in twenty states, and two additional states are organizing plans at the present time. Of these programs, eleven are statewide, and twenty-nine are local. Thirty-six are in operation with enrolled subscribers, while four are in the organizing stage, but as yet have no enrollment.

A conservative aggregate of the enrollment of these medical care programs is 2,476,321. However, there are only about 8,000,000 persons out of a total population of 136,000,000 Americans who are covered under the plans, or about six per cent of the total population. One of our major objectives must be to increase this movement rapidly and largely if we are to combat the Federal Program.

A study by the Research Council for Economic Security of Chicago, prepared upon data from the Health and Accident Underwriters Conference shows that more than 40,000,000 Americans are estimated to enjoy health and accident insurance protection care under voluntary programs, and the same study also shows that the rate of growth in number of persons protected by health and accident insurance policies has been much more rapid than the rate of growth in premium income.

The reason is that health and accident and hospitalization protection has been made more generally available to the working people through the rapid development of group insurance. In 1920 there were about 4,000,000 people covered by voluntary health and accident insurance; in 1944 there were more than 40,000,000.

The Research Council very properly says, "This makes it evident that the percentage of population protected is rapidly approaching a figure which will refute completely the argument of advocates of compulsory governmental programs, that the people who really need protection are not being reached under the voluntary programs now in operation."

The objectives, the problems, and the possibilities of professionally supported prepayment programs are everywhere broadly the same. They are a product of American medicine as a whole, and are not the exclusive development or property of any one segment or district or state. They seek to solve a problem, national in scope. Therefore, the principles which guide this movement for voluntary prepaid medical care are universal, even though there may be variations in details.

Distasteful though it may be, the time has come when the medical profession must concern itself with economic problems, because if we abandon the control of the economy of medicine to some authority outside the profession, and particularly to the Federal Government, scientific freedom cannot survive.

Our political leaders are not unmindful of the

continued on page 53

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for adequate infant nutrition

FORMULAC, newly introduced on the market, is the trade name for a fortified infant food which makes supplementary vitamin administration unnecessary.

FORMULAC (a reduced milk in liquid form) was developed by E. V. McCollum. It is sufficiently supplemented with vitamins and minerals to render it an adequate food for babies. Incorporation of the vitamins *into the milk itself* eliminates the risk of maternal error or carelessness.

FORMULAC presents a flexible basis for formula preparation. Supplemented by carbohydrates at your discretion, it may readily be adjusted to fit each individual child's needs.

FORMULAC has been tested clinically, and found satisfactory in promoting infant growth and development.

FORMULAC is inexpensive—within price range of even low income groups. It is on sale at most grocery and drug stores.



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THE VOLUNTARY WAY

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general state of popular sentiment and opinion in favor of some type of health insurance. That is why the administration at Washington has moved so swiftly for the adoption of the latest version of the Wagner-Murray-Dingell Act. If the medical profession does not go "all out" in providing the medical and hospital care that is needed, it is obvious that public demand will encourage the political leaders to have the Government provide it.

In an effort to dramatize poor conditions of health among the American pepole, who incidentally are the healthiest nation in the world, and have been made so by our free independent type of medical care, as opposed to "state medicine" in Europe, President Truman asserts that "5,000,00 men were rejected from the draft because of some disability," and infers that under a federalized medical program, this number would be cut down materially.

Of course, in using this fact as an argument for federalized or socialized medicine, the proponents do not break down those figures to show that a large percentage of those rejected were totally disqualified because of blindness, or deafness, or the loss of a limb, nor do they point out that more than 700,000 had mental or nervous diseases, or that a half million were mentally deficient; nor do they disclose that in this figure are included hundreds of thousands of men who were rejected by selective service for certain conditions which socialized medicine could not have changed. They do not tell you either, that although in the United States, thirty-eight per cent of those called for induction were rejected, in England, where the standards of induction were not so high as those in the United States, the rate of rejection was fifty percent, and England's socialized medicine health insurance program has been in operation for a whole generation.

* * *

The battle for winning the support of the rest of electorate of this country is now on, and it will be very largely action and facts which will tell the story best. I have pointed out that the people as a whole are in favor of some form of health insurance, but when the cost of the federal program is realized, they will be very much opposed to this burden, which is likely, under the provisions of the pending bill to run to about ten per cent of the entire national payroll.

Studies which have been made of the several types of prepayment plans sponsored by the physicians show that the cost of coverage may be estimated at about one-fourth of the cost of a federal program.

* * *

I would like to stress the need for a national voluntary prepayment health service plan, uniform in general principles, with reciprocity among states, so that practically the same benefits are offered in any or all parts of the country at approximately the same subscription rates, to facilitate enrollment of national groups, as well as to permit a continuation of coverage to those whose work moves them from one section of the country to another.

Roughly, sixty per cent of the business in America is on an inter-state basis, and the necessity, therefore, of some master plan in the various states to cover people moving about from one state to another is most important.

I believe, therefore, that the medical profession must offer a national medical program which guarantees that the subscriber receive the service he needs when he needs it, any place in the United States.

* * *

The opportunity is before us, in every state all over the country, to show what the voluntary plans can do. If the Doctors do not act upon this opportunity, evidence that the government will enter the field is overwhelming. The hour is late. Government will not wait, because the people will not wait. People want a group prepayment program. The medical profession, their own Doctors, must supply and operate a voluntary program. They will expect it. They will prefer it. As Doctors of Medicine, we should continue to control our own profession. We must act with the greatest speed, consistent with safety and orderly progress, to develop group medical care programs.

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THE COMPULSORY PROPOSAL

concluded from page 45

question, health insurance presents not a major threat but a new, great opportunity.

Another question is summarized in the phrases about "regimentation," "a czar over medicine," etc. There is one sure way for the medical profession to see that what it doesn't want doesn't happen, even by inadvertence; that is to participate in planning the program. If you do, I am sure you will find you are working side by side with friends of the profession. There is no problem here that can't be solved by men of good will.

Professional Participation and Program Planning

I hope that I have succeeded in pointing out some of the essential differences between a system of State medicine and a system of health insurance. The first means a change from private medicine to public medicine. The second means changing from a pay-as-you-are-sick method to a prepayment method for spreading the cost of medical care.

However, even with this essential difference, it should be recognized that the medical profession has a justifiable concern as to the effect of a system of health insurance on the profession. The medical profession has a right to insist that the high standards of medical practice achieved in this country shall not only be maintained but also encouraged to advance as in the past. The medical profession has a right to insist that the doctor-patient relationship shall not be impaired in any way. It has a right to insist that its members shall be remunerated adequately for the services they render. Therefore, I believe that the medical profession should assist in developing legislation and should participate in the administration of the system that is enacted. I trust, however, that I may be forgiven for suggesting that organized medicine in this country should not give the impression of unqualified opposition to any governmental attempt to spread the costs of medical care.

* * *

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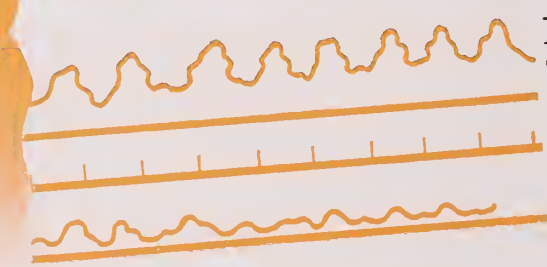
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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

MEETING OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION, AT CHICAGO, DECEMBER 3-6, 1945

Report of ALEX M. BURGESS, M.D., *Delegate from the Rhode Island Medical Society*

YOUR delegate attended sessions of the House of Delegates and was also privileged to attend the Conference of Presidents and other Officers of State Medical Societies which was held on December 2.

The meetings were all well attended and a great deal was accomplished. At the conference of Presidents and other Officers, four interesting papers were presented. The paper by Arthur J. Altmeyer, Chairman of the Social Security Board, was in reality a well-prepared and clear summary of the main provisions of the bill presented by Senators Wagner and Murray and Representative Dingell. Following this, two clear and forceful communications, one by Dr. Howard of Bridgeport, Connecticut, and one by Dr. Gilman of California were read. These stated clearly the point of view of the majority of the medical profession, emphasizing the harm to the public that would result from compulsory sickness insurance and from federal regimentation of the medical profession. Mr. John F. Hunt of Chicago outlined a plan for a National Health Congress in which medicine, dentistry, nursing, and pharmacy would be represented as well as labor, industry, and agriculture. It was your delegate's privilege to point out that a council of exactly this nature already is in existence in Rhode Island.

The sessions of the House of Delegates were characterized by the usual long list of resolutions which were referred to reference committees, studied and reported back to the House for action. On December 3, Major General Hawley, Medical Director of the Veterans' Administration, gave a clear and informative talk to the Delegates on the plans of his organization for the care of veterans. A summary of his address is appended to this report.

The following are, in the judgment of your delegate, the most important actions taken by the House of Delegates:

Medical Care of Veterans — A resolution was adopted affirming support of the program of medical care of veterans as expressed by General Hawley. Also, a resolution opposing service to veterans for non-service connected disabilities.

Discharge of Physicians — A resolution requesting the immediate discharge of all physicians from the armed forces who are not vitally needed was adopted.

Children's Bureau — A resolution that the A.M.A. petition the government to transfer the personnel and facilities of the Children's Bureau from the Department of Labor to the U. S. Public Health Service was adopted.

E.M.I.C. — Disapproval was expressed in a resolution for the extension of the E.M.I.C. or enlargement of its benefits as proposed in the Pepper Bill which was adopted.

Compulsory Health Insurance — There was disapproval in general of the principle of federally controlled compulsory health insurance and in particular of the proposal of President Truman that such a program be instituted and of the same program as outlined in the latest Wagner-Murray-Dingell bill. The reasons for disapproval were stated as follows:

1. **The bill is "founded on the false assumption" that solution of the medical care problem "is a panacea for all the troubles of the needy."**
2. **"This is the first step in a plan for general socialization, not only of the medical profession, but of all professions, industry, business and labor."**
3. **Experience in other countries shows that "inferior medical service results from compulsory health insurance."**
4. **The program, "enormously expensive," would increase taxes "for the entire population of the United States."**
5. **Voluntary prepayment plans, now sponsored by organized medicine in 24 states, "will accomplish all the objects of this bill with far less expense to the people," and will provide "the highest type of medical service without regimentation."**

This disapproval was accompanied by approval of plans of hospital construction as explained in the Hill-Burton Bill. Disapproval was also officially expressed of the idea of widespread Government subsidy of research which would tend to limit the freedom of such research and to take it from the control of the universities.

Voluntary Insurance Plans — Support of plans for voluntary prepaid medical insurance with aid to all states in maturing and perfecting such plans.

Philippine Medicine — It was voted to send a request to the Federal Administration to give to hospitals in the Philippines and to the University surplus army supplies as the need is very great.

continued on page 61

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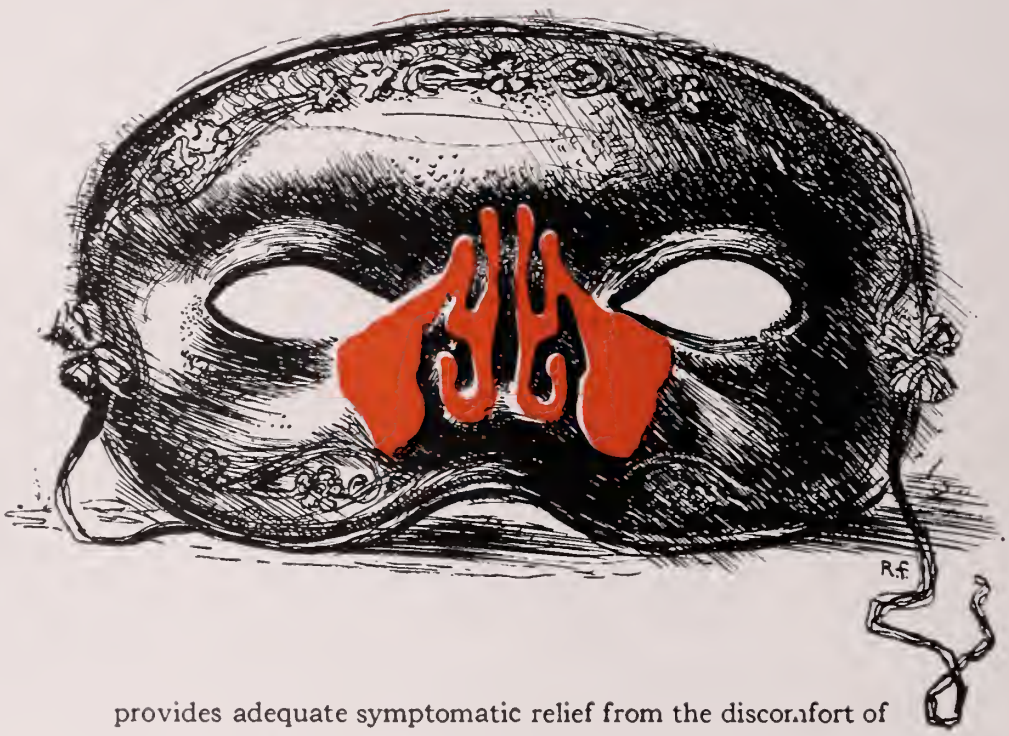
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REPORT OF MEETING OF AMA HOUSE OF DELEGATES

continued from page 57

Internes and Residents — It was voted to request information as to the future plans of the military authorities regarding internes and residents and to request that there be a more prompt approval of residencies by the Council and a general liberalization of policy.

Plasma — There was an approval of the Red Cross plan to donate to civilian authorities dried plasma unused by the armed forces.

Publicity — Disapproval was shown by a vote of 106 to 61 of a resolution introduced by the California delegates that full-time paid employees of the A.M.A. be restricted in their activities to carrying on the work of their positions. This was frankly aimed at restricting the public utterances of Dr. Morris Fishbein. There was also disapproval of the resolutions introduced by California which would cause all official publicity to be funneled through the Council on Legislation and Public Relations.

Miscellaneous Topics — The formation of a National Health Congress representing medicine, dentistry, nursing, pharmacy, agriculture, labor, and industry, already described as quite similar to the Health Council established in this state, was advocated.

Dr. Roger Lee was installed as the new President and Dr. H. H. Shoulders, for many years speaker of the House was chosen as President-Elect. Among other officers, Dr. James R. Miller of Hartford was elected Trustee.

It was decided to hold the next annual session at San Francisco, July 1-6, 1946.

MEDICAL CARE OF VETERANS

(Summary of address by General Hawley given before the House of Delegates of the American Medical Association on December 3, 1945.)

The Problem — To give a high standard of medical care to 20,000,000 veterans. After the last war there were 4,000,000. Medical care was of a low standard for the following reasons: A full-time medical corps was hurriedly organized, sometimes without proper check on the qualifications of its members; the Medical Department was submerged under lay administrators; civil service dictated the selection of the men and kept them in. The result was medical job holders and clock watchers. It is this old type of medical officer who now opposes the improvements contemplated by General Hawley.

To care for 20,000,000 veterans with a full-time staff is quite impossible. Only with the help of organized medicine can the problem be solved. There is heavy pressure being brought to bear by Congress to make the Veterans' Administration take over the existing Army and Navy emergency hospitals. This is not practicable because they are, so many of them, located in the country where civilian medical help is not available, and it is on civilian medical help that the Veterans' Administration must depend. There are now only 23,000 medical officers available in the service and many wish to leave and are leaving.

The new veterans' hospitals will be staffed for the most part by part-time physicians who are in private practice. They will be set up where possible in connection with medical schools and in other large centers without medical schools and will be organized with internships and residencies, and their teaching functions will be developed. Every hospital will have an attending staff as in civilian general hospitals.

The out-patient care of veterans presents an even greater problem. This will be worked out with the aid of organized medicine which to date has been most cooperative. Three plans have been developed so far. One is in operation in Monmouth County, New Jersey. It is set up with the aid and advice of the local medical society. There is also one in Michigan with the Michigan Medical Service, and one in Kansas with the state society. The Veterans' Administration would like to deal with every state in the same way.

General Hawley is committed to a program of procuring the best in American medicine for the veteran. He says, "If I am not permitted to bring the best in American medicine to the veteran, I shall quit at once."

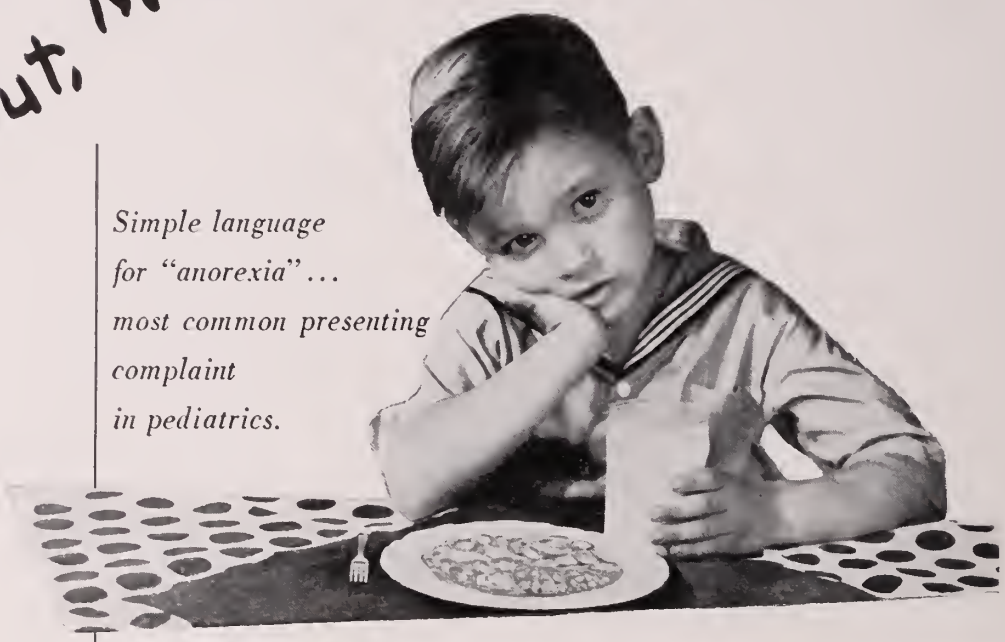
The State is the trustee of the Cash Sickness Fund. It can be used for no other purpose than to pay benefits to our citizens who are unable to work because of illness. This is a sacred trust and it becomes our duty to safeguard the fund so that benefits may be paid promptly to those who are eligible for them.

Various bills have been introduced at recent sessions of the legislature proposing certain changes in the present law. No definite action has been taken on these proposals because of objections made by certain well-meaning groups. I do not propose to discuss the wisdom of these objections, but I am convinced that they have been sincerely raised.

For the purpose of safeguarding this fund in the public interest I recommend that the General Assembly appoint a committee, or grant me the authority to appoint a commission, which will report to you on the proper changes to be made after a complete study.

. . . Governor John O. Pastore, in his message to the Rhode Island General Assembly on January 2, 1946.

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EDUCATIONAL OPPORTUNITIES FOR MEDICAL VETERANS AND OTHER INTERESTED PHYSICIANS AT RHODE ISLAND HOSPITAL

At the request of the Committee on Postgraduate Education of the Rhode Island Medical Society the following statement has been prepared by the General Education Committee of the hospital. It is presented primarily for the benefit of those medical officers who are returning to civilian practice and who do not plan to take residencies or other staff positions. It is open to all registered physicians but where the number of visitors is limited preference will be given to men who have served in the armed forces.

The exercises listed below are some of them open to physicians generally. In the case of others the number of visitors will be limited and these will be marked with an asterisk (*). In the case of activities so marked it will be necessary for the physicians who wish to attend to apply at the office of the Assistant Superintendent, Dr. Henry S. Joyce.

Department of Medicine

1. Medical Conference

Weekly — Saturdays — 10:15-11:15 A. M. at Peters House Auditorium. The program consists of presentation and discussion of cases from the service, often chosen to illustrate particular conditions and problems in clinical medicine. At frequent intervals the value of these meetings is enhanced by the presence of eminent visiting clinicians from out of the state.

*2. Chief's Rounds**

Thursdays — Wards A and K — 10:00-11:30 A. M. — Drs. Wing and Burgess. These rounds are intended for bedside study of important medical problems on the ward services. They are conducted by the two physicians-in-chief alternating on the male and female wards.

*3. Thoracic Clinic**

Thursdays — 11:30 A. M. — at Clinic Building —Dr. DeWolf. This Clinic is carried on in collaboration with the Departments of Surgery, Laryngology and Roentgenology. Patients suffering from diseases of the respiratory system are examined and their problems discussed.

*4. Diabetic Clinic**

Mondays and Fridays — 11:00 A. M. — Out-Patient Building. Out-patient care of diabetics.

Note: Certain other clinics which have been limited or discontinued during the war will be re-established on a full peacetime basis in the near future and opportunities will probably be offered for a limited number of visitors to attend them. Among such clinics are those on allergy and on diseases of the gastrointestinal tract.

Department of Surgery

*1. Surgical Grand Rounds**

Fridays — 10:00 A. M.— Surgical wards — Dr. E. M. Porter. These rounds comprise a combined visit by both surgical services to all surgical wards and a critical discussion of the diagnostic and therapeutic surgical procedures in use.

Department of Roentgenology

*1. Interpretation of films**

Daily—X-ray laboratory—9:00-12:00 A. M.— Drs. Martineau and Gerber. The daily study of routine films of patients from all the services of the hospital.

*2. Radiotherapy**

X-ray laboratories — Dr. Batchelder. Modern methods of radiotherapy applied to hospital patients.

Department of Pathology

1. Clinico-Pathological Conference

Fourth Tuesday in the month — 12:00 noon — Peters House Auditorium. Given in collaboration with the Departments of Medicine and Surgery. Presentation of cases by clinicians, general discussion and then a presentation of autopsy findings with demonstrations of gross and microscopic evidence by the pathologists.

*2. Tumor Clinic**

Wednesdays — 11:00 A. M. — Clinic Building — Conducted by the Departments of Pathology in collaboration with all the clinical departments of the hospital. Study and diagnosis and recommendations for treatment of patients referred to the Clinic by ward and out-patient services and private physicians.

Other Departments

The following departments of the hospital will also admit a limited number of qualified physicians

continued on page 67

Introducing

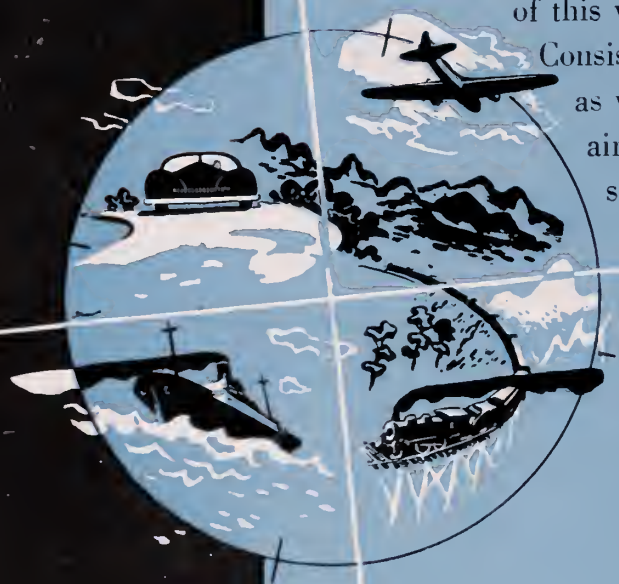
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1. Holling, H. E.; McArdle, B., and Trotter, W. R.: Lancet, *1*:127, 1944.
2. Hill, I. G. W., and Guest, A. L.: Brit. M. J. *2*:6, 1945.
3. A Critical Study of Seasickness Remedies, No. 1, Royal Naval Medical Bulletin *24*:3, 1943, Abstracted, Bulletin of War Medicine *18*:1242, 1944.
4. Lillienthal, J. L.: Jl. Aviation Med. *16*:59, 1945.

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DISTRICT MEDICAL SOCIETY MEETINGS

KENT COUNTY MEDICAL SOCIETY

The annual meeting of the Kent County Medical Society was held at the Show Boat December 13. Dr. Leo Duquette, President, presided. The Secretary and the Treasurer, Dr. Joseph K. Harrop and Dr. John A. Mack, respectively, turned in their reports for the past year.

The retiring President welcomed two members of the Society returned from war duty, Dr. Whitman Merrill and Dr. Peter Erinakes. After commenting on poor attendance throughout the past year, Dr. Duquette called for the report of the nominating committee.

The report was made by Dr. Fenwick Taggart. Officers elected were:

President: Whitman Merrill, M.D.
Vice-President: Peter Erinakes, M.D.
Secretary: Jeannette E. Vidal, M.D.
Treasurer: John A. Mack, M.D.
Delegate to R. I. Medical Society: Rocco Abbate, M.D.
Censor: Fenwick Taggart, M.D.
Council: Fenwick Taggart, M.D.
Ethics: George Young, M.D.
Trustee: George B. Farrell, M.D.

Dr. Merrill rose to the presidency.

New business on the docket was brought up by Dr. George Young who reported a meeting held two months ago at Dr. Hardy's home concerning plans for a general hospital which would serve Kent County. After discussion by Drs. Merrill, Taggart, Mack, Hardy, Farrell, and Erinakes, Dr. Young moved that:

1. A committee representing Warwick, East Greenwich, West Warwick, and Coventry be formed to investigate the possibility of elevating a Memorial Hospital in Kent County
2. Discussion of detail be left with said committee
3. The committee be supplemented by local citizens of the four sectors
4. The committee be limited in number
5. The committee report every month
6. The name of the hospital be Kent County Memorial Hospital.

The motion was adopted.

The nominations of Dr. George B. Farrell for West Warwick, Dr. Fenwick Taggart for East Greenwich, Drs. Charles Young and Arthur Hardy for Warwick, and Dr. Whitman Merrill for Coventry were voted upon and accepted as the committee on hospital investiation.

The meeting was adjourned at 6:15 on the motion of Dr. Mack. Dinner was served.

Members present, 14; guests, 2.

JEANNETTE E. VIDAL, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Library, Monday, December 3, 1945. The meeting was called to order at 8:45 p. m. by the President, Dr. B. Earl Clarke. The minutes of the previous

continued on page 67



WHITMAN MERRILL, M.D.
of Washington, R. I.
(Recently released as Lt. Comdr. in the U. S. Naval Reserve)
PRESIDENT *of the*
KENT COUNTY MEDICAL SOCIETY, 1946

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154.*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60.

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

PROVIDENCE MEDICAL ASSOCIATION

continued from page 65

meeting were read by the Secretary and approved by the Association. Since there were no applications for membership and no other business, Dr. Clarke immediately introduced the speaker of the evening, Dr. George W. Waterman, Chief of the Department of Gynecology at the Rhode Island Hospital.

Dr. Clarke discussed the histological changes in Practical Aspects of the Sterility Problem." His paper reported on 240 cases seen in private practice during the years 1938 to 1944. Dr. Waterman reviewed the important discoveries in the field of female endocrinology as applied to the reproductive function. He mentioned several valuable tests which may be done to prove the normality of various factors in the hormonal cycle. Some of these tests are too difficult or complicated to apply routinely. An endometrial biopsy taken a few hours after the onset of menstrual bleeding furnishes information from which the presence or absence of a normal monthly cycle can be determined.

Dr. Clarke discussed the histological changes involved in various structures. He showed many beautiful and instructive colored slides illustrating his remarks. In discussing the determination of the time of ovulation, Dr. Waterman expressed the opinion that the daily recording of basal temperature taken before arising in the morning is of striking value in determining the time of ovulation. He also commented favorably upon the Rubin Test as a diagnostic and therapeutic measure in dealing with tubal patency.

Dr. Martineau discussed the X-ray aspects of the problem, particularly the diagnostic and therapeutic value of lipiodol injection of the uterine cavity and the tubes.

In summing up, Dr. Waterman stated that it is difficult to properly evaluate the results of treatment in cases of sterility. In his series, proper follow-through was obtained in 190 cases. Of these, 65 women, or about 33 per cent, became pregnant. This is about an average result as compared with other statistics. Dr. Waterman called attention particularly to the fact that of 65 women who had a low basal metabolic rate and received thyroid treatment, 43 per cent became pregnant.

Questions were asked by Dr. Corvese and Dr. Cameron.

Collation was served. Attendance—64.

Respectfully submitted,

FRANK W. DIMMITT, M.D., *Secretary*

EDUCATIONAL OPPORTUNITIES FOR VETERANS

continued from page 63

to certain of their regular department activities. Interested physicians should apply to the office of the Assistant Superintendent, Dr. Joyce.

Department	*Chief*
Gynecology	Dr. Waterman
Neurosurgery	Dr. Pickles
Neurology	Dr. McDonald
Pediatrics	Dr. Buffum
Orthopedics	Dr. Harris
Fracture	Dr. Harris
Otolaryngology	Dr. Sargent
Ophthalmology	Dr. Messinger
Dermatology	Dr. Sawyer
Cardiology	Dr. Fulton
Physical Medicine	Dr. Magill

It is the earnest hope of the hospital that it may be privileged to give all reasonable assistance to those of our returning medical officers who can benefit by its aid.

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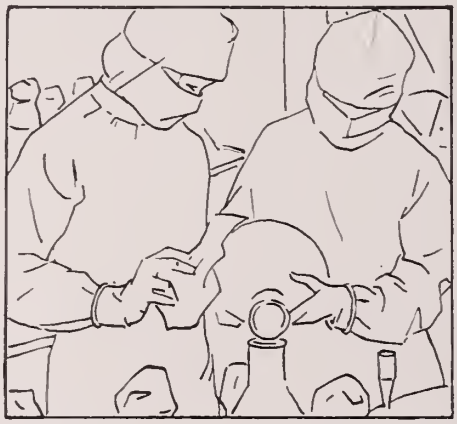
We are equipped to make impressions of the patient's ears, $6.50 complete.

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PENICILLIN SCHENLEY CONTROL

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. . . insures your confidence here



SCHENLEY LABORATORIES, INC
Producers of Penicillin Schenley
Executive Offices:
350 Fifth Avenue, New York City

At the Schenley Laboratories, a system of control of vast proportions insures maximum purity, potency, and pyrogen-freedom for the end product which bears the label Penicillin Schenley.

Since its production is safeguarded with such skill and precision at every step, members of the medical profession can feel the greatest confidence when they specify Penicillin Schenley.

Your Local Distributor for **PENICILLIN** SCHENLEY *is:*

Providence---THE CLAFLIN CO.

RHODE ISLAND MEDICAL SOCIETY, NECROLOGY, 1945

JOSEPH DeVERE BARBER, M.D., was born in Hopkinton, Rhode Island, on March 3, 1871. In 1893 he received his degree from P. & S. Columbia Medical College. He was a member of the Washington County Medical Society and a fellow of the Rhode Island Medical Society. Dr. Barber died July 27, 1945.

HARRY BROADMAN, M.D., was born in 1883. He attended Temple College and received his medical degree in 1910 from the Jefferson Medical College of Philadelphia. On June 3, 1913, he was admitted to fellowship in the Providence Medical Association and in 1916 he joined the Rhode Island Medical Society. Dr. Broadman died March 5, 1945.

CARL ROSWELL DOTEN, M.D., was born in Portland, Maine, on November 14, 1877. He attended Bowdoin College and received his medical degree in 1900. He was admitted to fellowship in the Providence Medical Association in February, 1903, and to the Rhode Island Medical Society in 1902. Dr. Doten died on April 21, 1945.

WILLIAM HINDLE, M.D., was born in Providence on February 28, 1876. He graduated from Georgetown in 1899 and received his medical degree from Harvard Medical School in 1903. He was admitted to fellowship in the Providence Medical Association in April, 1905, and in the Rhode Island Medical Society in 1905. Dr. Hindle died on July 26, 1945.

DOUGLAS P. A. JACOBY, M.D., was born in 1873 in South Whitehall, Pennsylvania. He studied medicine at Ohio State University. Dr. Jacoby was a member of the Newport County Medical Society and the Rhode Island Medical Society. He died August 27, 1945.

RAYMOND LUFT, M.D., was born on November 16, 1904, in Jersey City, New Jersey. He attended Rhode Island State College, receiving his B.S. in 1926, and McGill University where he received his medical degree in 1934. He was a past president of the Kent County Medical Society, and he joined the Rhode Island Medical Society in 1939. Dr. Luft died June 23, 1945.

FRANCIS HENRY McCAFFREY, M.D., was born April 12, 1913, at Cranston. He received his B.S. degree from Providence College in 1936 and his medical degree from the University of St. Louis on June 4, 1940. Dr. McCaffrey was admitted to the Providence Medical Association in October, 1942, and to the Rhode Island Medical Society in October, 1943. He died July 21, 1945.

WILLIAM SYLVESTER STREKER, M.D., was born October 11, 1885, in Providence. He was graduated from Jefferson Medical College in 1908. Dr. Streker was a past president of the Providence Medical Association, and he became a fellow of the Rhode Island Medical Society in 1912. He died July 8, 1945.

BERNARD LeROY TOWLE, M.D., was born in Malden, Massachusetts, on September 13, 1876. On June 23, 1897, he received his medical degree from Maine Medical College. He was a past president of the Pawtucket Medical Society, and became a fellow of the Rhode Island Medical Society in 1898. Dr. Towle died on February 6, 1945.

MICHAEL EDWARD VANCE, M.D., was born April 6, 1870, in Pawtucket. He attended New York University and Bellevue where he received his medical degree on May 7, 1895. Dr. Vance was a member of the Pawtucket Medical Society, and in 1916 he was admitted to fellowship in the Rhode Island Medical Society. He died on May 5, 1945.

MILTON KORB, M.D., was born in Providence on September 23, 1910. In 1939 he graduated from the University of Columbia Medical School, and he studied neurology as a fellow of Harvard Medical School for a year. Dr. Korb became a member of the Providence Medical Association in January, 1942, and a fellow of the Rhode Island Medical Society in January 1943. Dr. Korb died December 29, 1945.

CAMEL CIGARETTES

Medical Relations Division

ONE PERSHING SQUARE
NEW YORK 17, N.Y.

Dear Doctor:

You may recall having been asked the question: "What cigarette do you yourself smoke, Doctor?"

In the past few months every physician in private practice in the United States has been asked that same question...asked solely and clearly on the basis of personal preference as a smoker.

Three nationally known independent research groups did the asking in what we believe is one of the most impartial and most comprehensive surveys of physician preference ever conducted.

You may or may not be a cigarette smoker, but we believe you will be interested not only in the results of these surveys, but in the methods by which these results were obtained.

Yours very truly,

A. G. Clarke.

A. G. Clarke
Director
Medical Relations Division

CALEDONIA 5-1910

A physician asked us the question first—

A smoker himself, he asked: "What cigarette do most doctors smoke?"

We know that many physicians smoke, that many of them prefer Camels; but we couldn't answer the doctor's query.

We turned the question over to three nationally known independent survey groups. For months these three groups worked . . . separately . . . each one employing the latest scientific fact-finding methods.

This was no mere "feeling the pulse" poll. No mere study of "trends." This was a nationwide survey to discover the actual fact . . . and from the statements of physicians themselves.

> *To the best of our knowledge and belief, every physician in private practice in the United States was asked: "What cigarette do you smoke?"*

The findings, based on the statements of thousands and thousands of physicians, were checked and re-checked.

ACCORDING TO THIS RECENT NATIONWIDE SURVEY:

More doctors smoke Camels than any other cigarette



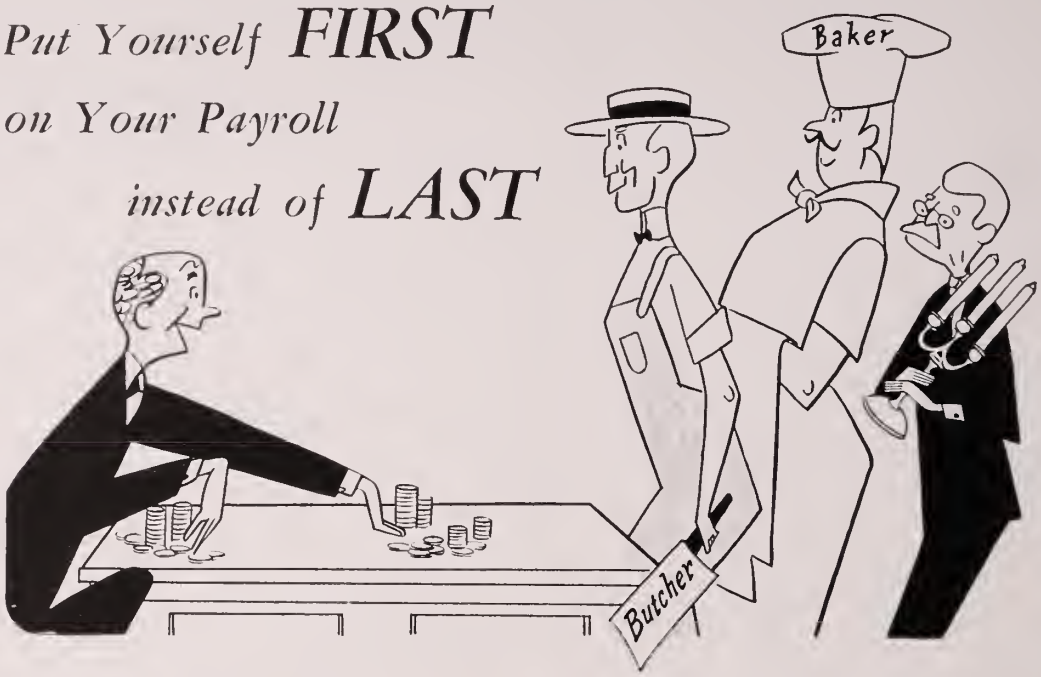
And by a very convincing margin!

Naturally, as the makers of Camels, we are gratified to learn of this preference. We know that no one is more deserving of a few moments to himself than the busy physician . . . of a few moments of relaxation with a cigarette if he likes. And we are glad to know that so many more physicians find in Camels the same added smoking pleasure that has made Camels such an outstanding favorite among *all* smokers.

CAMELS *Costlier Tobaccos*

R. J. Reynolds Tob. Co.
Winston-Salem, N. C.

Put Yourself **FIRST**
on Your Payroll
instead of **LAST**



How to Have Income for the Rest of Your Life

When you sit down to take care of your monthly bills, the butcher, the baker, the candlestick maker, each gets what's coming to him — but are you equally careful about setting aside something for yourself and your family?
Too many of us devote our income to meeting present and past expenses, and save only if there's something left over.

But why put yourself last on the list? Make a definite program for the future a regular part of your budget.

Read about The Connecticut Mutual's Retirement Income plan which enables you to enjoy real peace of mind. Let us send you a copy of our booklet, "What Is the Retirement Income Plan?"

The Connecticut Mutual Life Insurance Company

Walter K. R. Holm, Jr., *General Agent*
and Associates
Suite 1814, Industrial Trust Building, Providence 3, R. I.

Please send me a copy of your booklet "What Is the Retirement Income Plan?"

NAME ..... DATE OF BIRTH .....

ADDRESS .....

CITY ..... STATE .....

OUTPATIENT NEUROPSYCHIATRIC TREATMENT AVAILABLE TO VETERANS IN RHODE ISLAND

(As of January 1, 1946)

FOR SERVICE CONNECTED VETERANS

A veteran has a service connected disability if it has been adjudicated a disability which has been adjusted by the Veterans Administration as incurred in or aggravated by military service.

Eligibility for neuropsychiatric outpatient treatment by the Veterans Administration

A veteran is eligible for neuropsychiatric outpatient treatment if he is service connected for a neuropsychiatric disability or if his neuropsychiatric condition is adjunct to another service connected disability.

Determination of eligibility

Service connected status may be determined by

a. Asking the veteran whether he is receiving a pension for a neuropsychiatric disability.

b. Asking the veteran whether he has a letter in his possession from the Veterans Administration informing him that his neuropsychiatric claim has been allowed.

c. Making inquiry at the following Veterans Administration offices:

Regional Office, Providence, R. I.

Contact Division, 100 Fountain Street; Tel. GAspee 3475

Local Contact Offices

Newport, Room 256, Federal Building; Tel. Newport 1469

Pawtucket, 35 High Street; Tel. Blackstone 2972

Warren, Post Office Building; Tel. Warren 1466

Warwick, Room 15-16, City Hall, Apponaug, R. I.; Tel. Greenwood 2016

Westerly, Washington Trust Building, 23 Broad St.; Tel. Westerly 5335

Woonsocket, Stadium Building, Tel. Woonsocket 5745

Medical and psychiatric examinations to determine type of therapy indicated in individual cases are made at the Regional Office or by fee basis psychiatrists designated by the Veterans Administration.

continued on page 75

FOR NON-SERVICE CONNECTED VETERANS

A veteran's disability is considered non-service connected when his service records do not make out a prima facie case of service connection or when he has been unable to introduce complete material evidence to substantiate his claim that the physical or mental condition was incurred in or aggravated by military service. Pending adjudication of a claim for a neuropsychiatric condition, a veteran's disability is not considered service connected. He therefore is not eligible for neuropsychiatric outpatient treatment from the Veterans Administration until such time as his claim is allowed.

Eligibility for Neuropsychiatric Outpatient Treatment

Any non-service connected veteran living in the State of Rhode Island is eligible for treatment or referral for treatment as offered by the following:

1. *State Vocational Rehabilitation Division*
   Address: 205 Benefit Street, Providence, R. I.
   Telephone: GAspee 1410; ask for Supervisor, Division of Rehabilitation.

   Services Available:
   Complete vocational rehabilitation services, which may include psychiatric treatment by an approved psychiatrist or outpatient neuropsychiatric clinic.

   Eligibility:
   Veterans with remediable physical or medical employment disabilities are given vocational rehabilitation services to make them employable. Medical treatment is limited to those whose disabilities are not acute and who are considered likely to respond to a limited amount of treatment. Fees will be adjusted to meet the individual need.

2. *The Neuropsychiatric Outpatient Clinic of the Charles V. Chapin Hospital*
   Address: Eaton Street, Providence, R. I.
   Telephone: DExter 7400; ask for Psychiatric Social Worker
   Clinic Days and Hours: Monday and Friday mornings from 9:00 a. m.; by appointment

continued on page 75



PENICILLIN in CELLULITIS

Serious local infections such as cellulitis due to hemolytic streptococcic infections—with or without bacteremia—respond rapidly and dramatically to Penicillin.

Initial dosage of 15,000 to 20,000 units is advised. Constant intravenous injection of an isotonic sodium chloride solution follows, allowing administration of 5,000 to 10,000 units every hour, or 120,000 to 240,000 units in a twenty-four hour period. If this method is found inadvisable, 20,000 to 40,000 units may be injected intramuscularly every three or four hours.*

Bristol Penicillin, because of its low toxicity and freedom from pyrogens, its absolute sterility and standard potency, provides dependable therapeutic action.

For additional current literature on the clinical uses of this potent antibiotic, refer to your issues of the BRISTOL PENICILLIN DIGEST.

*Keefer C. S. et al.: New Dosage Forms of Penicillin, J.A.M.A. 128: 1161 (Aug. 18) 1945.

BRISTOL
LABORATORIES
INCORPORATED

Other products of Bristol Laboratories include high-type parenteral medications such as Epinephrine Hydrochloride, Liver Injection, Estrogenic Substance in Oil, and Phenobarbital Sodium.

SYRACUSE 1, NEW YORK

Formerly Cheplin Laboratories Inc.

PSYCHIATRIC TREATMENT FOR VETERANS

For Service Connected Veterans

continued from page 73

Outpatient Treatment, Including Emergency Treatment, is Available as Follows:

1. Psychiatrist at the Regional Office*
2. Fee basis psychiatrist
3. Neuropsychiatric outpatient clinics under contract with the Veterans Administration (see below)
4. Fee basis physician (if Regional Office or psychiatrist too distant from the veteran's home).

Location of Above Services

1. *Veterans Administration, Regional Office, Providence, R. I.*
   Address: Medical Division, Post Office Annex
   Telephone: Gaspee 3475; ask for Chief Medcal Officer
   Day and Hours: 8:00 to 4:30, Mon.-Fri.; 8:00 to 12:00 on Sat.
2. *Neuropsychiatric Outpatient Clinic of the Charles V. Chapin Hospital (under contract)*
   Address: Eaton Street, Providence, R. I.
   Telephone: Dexter 7400
   Appointments: Original appointment must be made by Chief Medical Officer, Veterans Administration Regional Office (Tel. GA. 3475)
   Clinic Days and Hours: Tuesday mornings by appointment.
3. *Butler Hospital Outpatient Service (under contract)*
   Address: 305 Blackstone Boulevard, Providence, R. I.
   Telephone: GAspee 3456
   Appointments: Original appointment must be made by Chief Medical Officer Veterans Administration Regional Office (Tel. GA. 3475)
   Clinic Days and Hours: Monday, Wednesday and Thursday 9:00-4:00; Tuesday evening 7:00-10:00. By appointment.
4. *Fee Basis Physicians and Psychiatrists*
   For name and location of the above, telephone Regional Office or local Contact Office.

Medical Data: An abstract of the veteran's medical record will be supplied by the Regional Office prior to first appointment.

Fees: There is no charge to service connected veterans for outpatient treatment. Expenses authorized by Veterans Administration include necessary travel and meals.

*A mental hygiene clinic is to be established as soon as qualified personnel becomes available.

PSYCHIATRIC TREATMENT FOR VETERANS

For Non-Service Connected Veterans

continued from page 73

Medical Data:
The referring physician is requested to send in medical data on veteran prior to appointment.

Eligibility:
Any non-service connected veteran who is living in Rhode Island and who cannot afford the services of a private physician.

Fees:
A charge is made of 25c per visit in addition to a charge of 25c for the clinic card on the first visit. There is a variable charge for X-rays, medicines, etc.

3. *Butler Hospital Outpatient Service*
   Address: 305 Blackstone Boulevard, Providence, R. I.
   Telephone: GAspee 3456; ask for Chief of Outpatient Service
   Days and Hours: Monday, Wednesday and Thursday; 9:00 to 4:00. Tuesday evening 7:00 to 10:00. By appointment.
   Eligibility: Any non-service connected veteran is eligible.
   Fees: In accordance with ability to pay.

ALKALOL

as its name implies is alkaline. Its alkalinity, salinity and saline content are approximately those of the blood.

Used in the treatment of mucous membranes and irritated tissues it is therapeutically correct.

ALKALOL is non-toxic and does not irritate even inflammed membranes, yet it is notably soothing, cooling and effective.

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1896 - 1946

THE ALKALOL COMPANY

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Samples to the Profession

Not for just a year

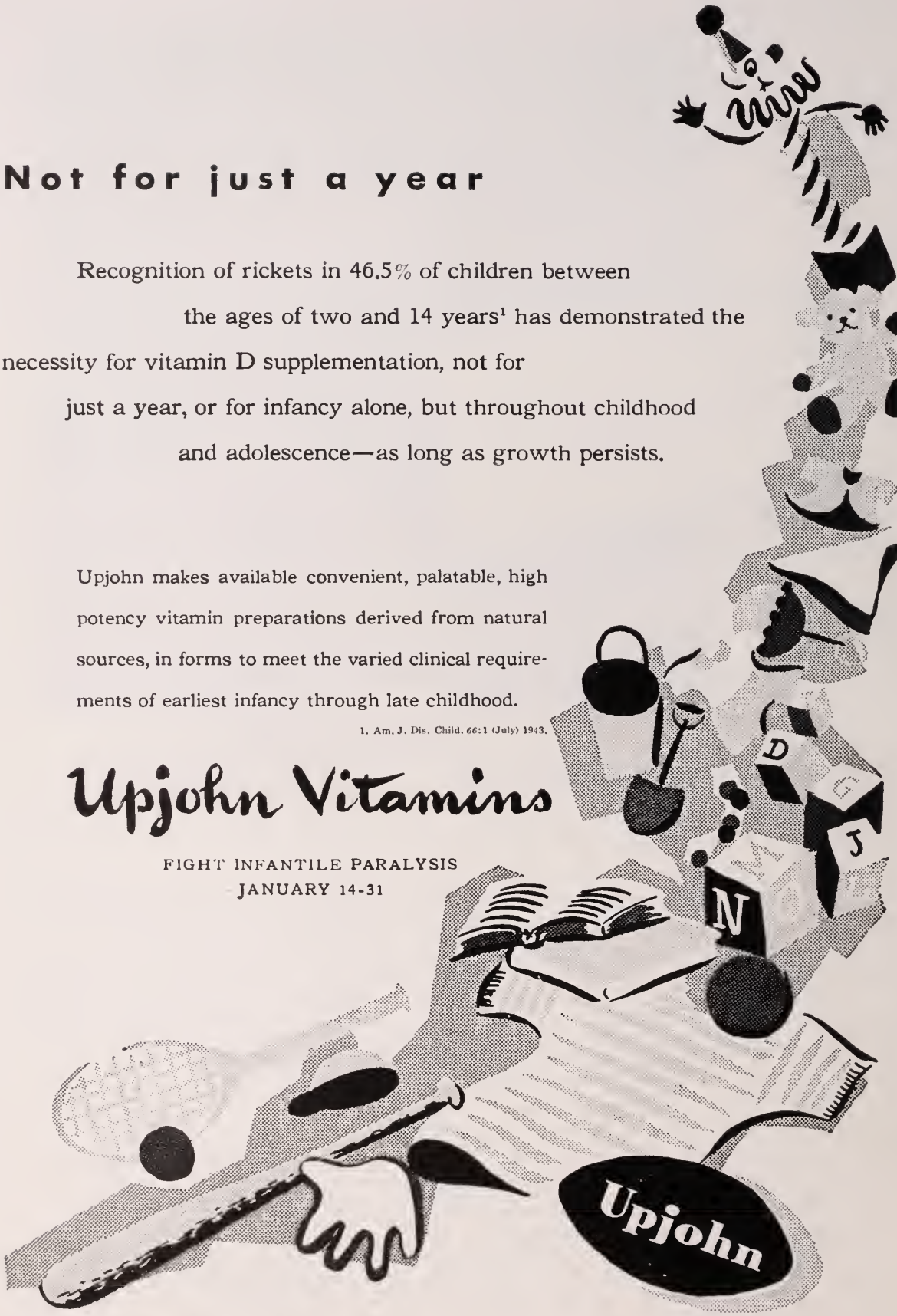
Recognition of rickets in 46.5% of children between the ages of two and 14 years[1] has demonstrated the necessity for vitamin D supplementation, not for just a year, or for infancy alone, but throughout childhood and adolescence—as long as growth persists.

Upjohn makes available convenient, palatable, high potency vitamin preparations derived from natural sources, in forms to meet the varied clinical requirements of earliest infancy through late childhood.

1. Am. J. Dis. Child. 66:1 (July) 1943.

Upjohn Vitamins

FIGHT INFANTILE PARALYSIS
JANUARY 14-31



FINE PHARMACEUTICALS SINCE 1886

Kalamazoo 99, Michigan

Uniform Satisfaction

Schieffelin
BENZESTROL
(2, 4-di (p-hydroxyphenyl)-3-ethyl hexane)

Clinicians agree that Schieffelin BENZESTROL is a significant contribution to therapy in that it is both estrogenically effective and singularly well tolerated, whether administered orally or parenterally.

"In our hands it has proved to be an effective estrogen when administered either orally or parenterally and much less toxic than diethylstilbestrol at the therapeutic levels" (Talisman, M. R.—Am. Jour. Obstet. & Gynec. 46, 534, 1943)

"During the last two years I have used the new synthetic estrogen Benzestrol in patients in whom estrogenic therapy was indicated. The results have been uniformly satisfactory". (Jaeger, A. S. Journal Indiana State Med. Assn. 37, 117, 1944)

Schieffelin BENZESTROL is indicated in all conditions for which estrogen therapy is ordinarily recommended and is available in tablets of 0.5, 1.0, 2.0 and 5.0 mg.; in solution in 10 cc. vials, 5 mg. per cc.; and vaginal tablets of 0.5 mg. strength.

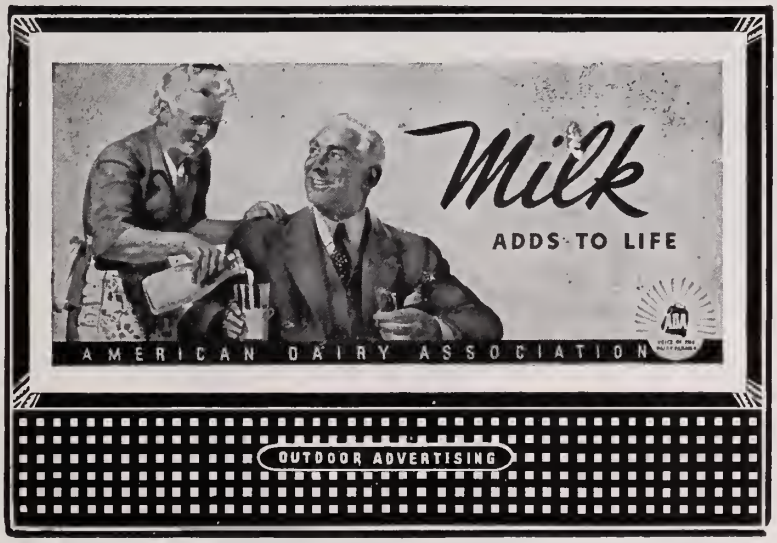
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Schieffelin & Co.

Pharmaceutical and Research Laboratories

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THIS BILLBOARD . . . like CERTIFIED MILK



speaks to those persons of middle life and beyond.

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H. P. Hood Co.	DE 3024
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Cascara Petrogalar

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A USEFUL LAXATIVE—Cascara Petrogalar combines the mild stimulating action of cascara with the softening effect of homogenized mineral oil. Prompt, easy evacuation of soft, formed stools is assured without undue strain or discomfort. Especially useful in treating stubborn cases and in elderly persons, its pleasant, dependable action helps to restore "habit time" of bowel movement. CASCARA PETROGALAR—an aqueous suspension of Mineral Oil, 65%, with aqueous extract of Cascara Sagrada, 13.2%.

Supplied in 8 fl. oz. and pint bottles

WYETH INCORPORATED • PHILADELPHIA 3 • PA.

TUBERCULOSIS IS PREVENTABLE

(Abstracts from the address by U. S. Senator Theodore Francis Green of Rhode Island at the 40th anniversary celebration of the Rhode Island State Sanatorium at Wallum Lake, October 28, 1945)

Tuberculosis, properly designated "the white plague," is preventable; yet last year, 1944, 279 Rhode Island citizens died of tuberculosis. Death, by some deep instinct, is most repellent to the human race. So is it not strange that the community looks with complacency upon the death of nearly 300 of its citizens when we know that these deaths are unnecessary?

Leading public-health officials are agreed that tuberculosis can be wholly eradicated within the borders of the continental United States within the next 25 years, and that there are four necessary steps to this end.

The first is early detection and isolation.

Periodically every individual in the community should be given a TB diagnosis by a free chest film. At the present time, the United States Public Health Service is planning a comprehensive program for early detection of tuberculosis. This program is under Dr. Hilleboe of the United States Public Health Service. This case-finding will be achieved by the use of modern portable X-ray equipment in charge of a staff of technicians. I understand that Rhode Island will participate in this program through funds made available to the department of public health by the Federal Government.

The second step is a thorough-going program of public education.

In 1936 Rhode Island had the highest incident of death from this disease of any New England State. It has now been reduced to a point where we are below the national average. Constructive public-health work and education are responsible for this progress. I call your attention to what was done by the public health department of New York City. . . . The need for greater education at public expense is indicated by the fact that nearly 53,000 men and women died of tuberculosis every year in the United States. The economic loss alone, not to count the human misery, is sufficient to call for a national crusade.

The third step is the removal of sources of infection.

The city slums and in many of our large cities, highly unsanitary factory lots and antiquated buildings account for a terrific toll. In a Federal pamphlet put out by the Federal Works Administration on postwar urban redevelopment, it is shown that blighted districts in our cities comprise about 20 percent of the metropolitan residential areas. This, however, is but part of the story. These blighted residential areas housing one-third of the population, account for 45 percent of the major crimes; 55 percent of the juvenile delinquency; 50 percent of all arrests; 35 percent of fires; 45 percent of cities' service costs; and what is especially interesting to us here today 60 percent of tuberculosis victims in the United States and 50 percent of all types of disease.

We can no longer tolerate slums and other blighted areas. The Congress of the United States has done much to develop a public-housing program. . . .

The fourth step is: Basic scientific research.

It is surely an indictment of our society when we find that before the war less than one-third of 1 percent of the national income was devoted to scientific research.

We need only to consider the $2,000,000,000 expenditure on the atomic bomb to realize the untold potentialities, if we organize an integrated, thoroughgoing program of scientific research, supported by public funds.

Just as the atomic bomb has opened up vast vistas on the horizon of the future for unlimited power devoted to peace as well as war, there are even greater vistas on the horizon in the social sciences. I include the great science of medicine, and especially the growing science of biochemistry. The discovery of penicillin by the biochemists has already saved many more lives than the atomic bomb has destroyed. As you know, the sulfa group of drugs has, to a large extent, reduced the menace of pneumonia and other pulmonary diseases. These discoveries in the field of biochemistry are all new. There is every reason to believe that with a proper amount of money devoted to scientific research, in a few years' time, we shall find something like penicillin which will at an early stage attack and destroy the tubercular bacilli and with that the terrible menace of the white plague.

Announcing...

A *THERAPEUTIC* FORMULA FOR VITAMIN DEFICIENCIES

HYPERVITAM

A THERAPEUTIC VITAMIN FORMULA

Daily dose of 3 CAPSULES contains:

Vitamin A	30,000 U.S.P. Units
Thiamine (B_1)	30 mg.
Riboflavin (B_2)	15 mg.
Niacinamide	150 mg.
Pyridoxine (B_6)	3 mg.
Calcium Pantothenate	15 mg.
Ascorbic Acid (C)	300 mg.
Vitamin D	3,000 U.S.P. Units
Alpha Tocopherol (E)	30 mg.

HYPERVITAM* embodies 2 basic principles in the therapy of vitamin deficiencies:

1. MORE COMPLETE FORMULA—vitamin deficiency symptoms are almost always multiple, rarely single.
2. EXCEPTIONALLY HIGH POTENCIES—vitamin deficiency diseases should be treated with *intensive* dosage . . . in divided doses for maintaining more uniform blood levels.

U. S. VITAMIN CORPORATION *pioneers again!*

1936—with multiple vitamin-mineral diet supplement—VI-SYNERAL

1940—with injectable preparation of Vitamin B complex factors—POLY-B SPECIAL

1943—with aqueous preparation combining fat- and water-soluble vitamins—VI-SYNERAL VITAMIN DROPS

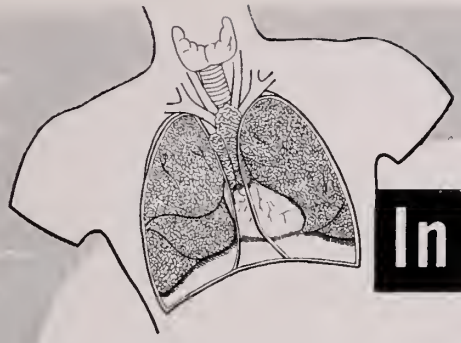
1945—with therapeutic vitamin formula—HYPERVITAM

*Trade Mark Reg. U. S. Pat. Off.

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In the Pneumonias

DURING the recent past, numerous investigations have shown that penicillin is the treatment of choice in the pneumonias (pneumococcic, streptococcic, staphylococcic).* Penicillin is virtually nontoxic, even in the massive dosages at times required. Its efficacy apparently is the same against sulfonamide-resistant and nonresistant organisms of the groups named. Even in advanced stages of the disease, in the presence of serious complications, penicillin usually proves a life-saving measure.

Since penicillin has become available in quantities that may well be adequate for all needs, it merits being the physician's first thought with every pneumonia patient.

*Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, Am. J. Dis. Child. 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, Pennsylvania M. J. 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:272 (July-Aug.) 1944.

PENICILLIN-C.S.C.

Penicillin-C.S.C. deserves the physician's preference not only in the pneumonias, but whenever penicillin therapy is indicated. Rigid laboratory control in its manufacture, and bacteriologic and biologic assays, safeguard its potency, sterility, nontoxicity, and freedom from pyrogens. The state of purification reached in Penicillin-C.S.C. is indicated by the notably small amount of substance required to present 100,000 Oxford Units. Because of this purity, incidence of the undesirable reactions, attributed by many investigators to inadequate purification, is greatly reduced.

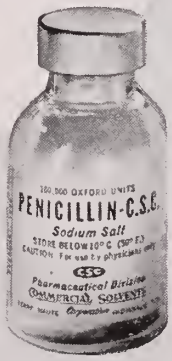
PHARMACEUTICAL DIVISION

COMMERCIAL SOLVENTS CORPORATION

17 East 42nd Street CSC New York 17, N. Y.

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

Penicillin-C.S.C. stands accepted by the Council on Pharmacy and Chemistry of the American Medical Association.



Dietary Protein after Surgery and Other Trauma

apparently must be maintained at a level above normal in order to assure proper wound healing* and at least average resistance against infection.** The feeding of meat, therefore, in adequate amounts, as soon as it can be instituted, appears doubly advantageous: the protein content of meat is high and of highest biologic value; the human digestive tract appears well adapted for handling meat protein.**

*" . . . in a variety of medical and surgical conditions there may occur a considerable depletion of body protein owing to a combination of factors, of which the two most important are a generally diminished protein intake and an enhanced protein catabolism. This situation inhibits wound healing, renders the liver more liable to toxic damage, impedes the regeneration of hemoglobin, prevents the resumption of normal gastrointestinal activity and delays the full return of muscular strength. It is obvious that to meet the situation an adequate supply of proteins and calories must be made available to the body. . . . This implies at least 150 Gm. of protein and 3500 calories, with as much as 500 Gm. of protein daily when trauma has been severe, as in serious burns." (HOFF, H. E.: Physiology, New England J. of Med. 231:492 [Oct. 5] 1944.)

**"Cannon . . . cites the evidence which indicates that diminished protein intake lowers resistance to infectious disease, and corroborates it by his own experiments . . . it seems probable that the small intestine is better adapted for handling protein (especially meat protein) than for other types of food. . . . it is especially well supplied with enzymes which attack protein, and the digestion of meat has been shown to be more complete than that of foods of vegetable origins." (CRANDALL, L. A., Jr.: The Clinical Significance of the Plasma Proteins, Memphis M.J. XIX:147 [Oct.] 1944.)

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES



Many of the scientific feeding programs developed at Hood's famous Cherry Hill Farm have been adopted by New England dairy farmers and have resulted in increased production and an improvement in the quality of the milk.

H. P. HOOD & SONS

biliary

renal

Colic

gastro-intestinal

The combination of atropine-like spasmolytic action with morphine-like analgesic power makes Demerol particularly well suited for the relief of pain due to smooth muscle spasm.

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1946

ARMOR AND ARMAMENTARIUM

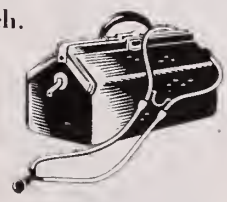
Guns are silent and grass grows in the foxholes, but there can be no peace treaty in the endless war on mankind's immortal enemy—Disease. Home comes the physician from his lifesaving on the battlefields of man-made death abroad to march again beside his colleagues who have so valiantly held the casemates of health at home.

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As this questioning year of 1946 opens with the world convalescing from malignant political disease, we would like to claim the privilege of welcoming the thousands of physicians returning from unparalleled service on war fronts—of saluting those who shouldered such heavy burdens at home—of expressing the confidence that the traditional unity of the profession armed with new and potent weapons will drive the front lines of the war on disease ever forward.

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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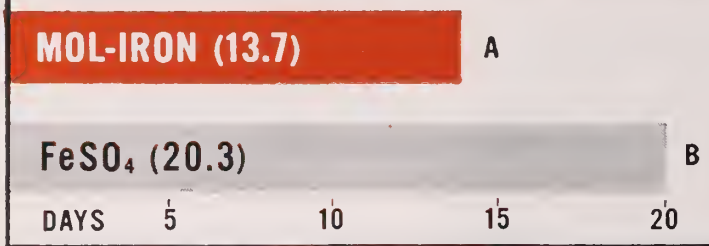
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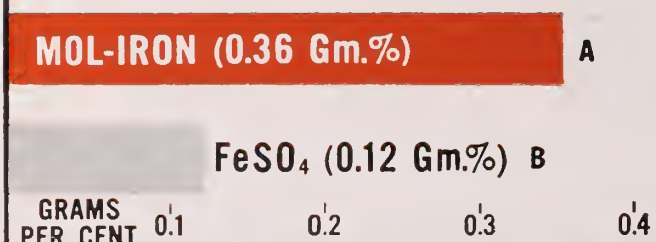
RAPIDITY OF CLINICAL RESPONSE (Days)



(A) Completely effective therapeutic response (return to normal blood values) was obtained in an average of 13.7 days of Mol-Iron therapy.

(B) Ferrous sulfate therapy *failed* to produce normal hemoglobin values after an average of 20.3 days.

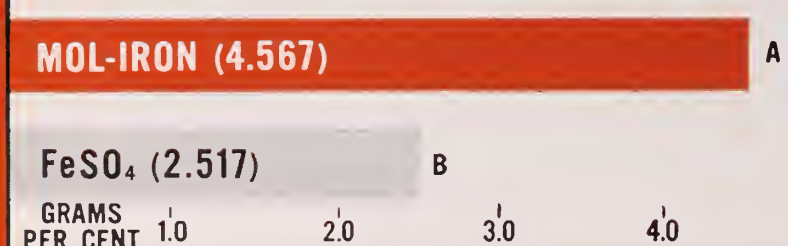
AVERAGE DAILY HEMOGLOBIN INCREASE (Gm. Per Cent)



(A) The group treated with Mol-Iron averaged a daily hemoglobin increase of 2.48 per cent (0.36 Gm. per cent).

(B) The group treated with ferrous sulfate showed an average daily gain of hemoglobin of 0.8 per cent (0.12 Gm. per cent)—a response about one-third as effective.

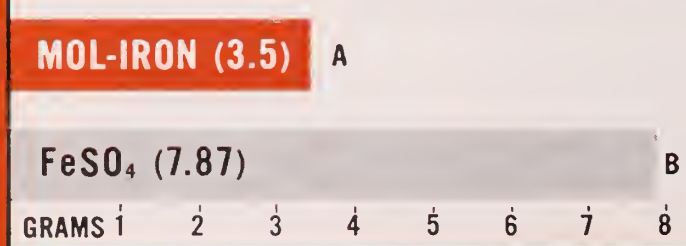
TOTAL HEMOGLOBIN INCREASE (Gm. Per Cent)



(A) The total hemoglobin increase (in an average of 13.7 days) averaged 31 per cent (4.56 Gms. per cent) in the Mol-Iron treated group.

(B) A mean gain of only 17 per cent (2.51 Gms. per cent) hemoglobin resulted in an average period of 20.3 days during which the ferrous sulfate treated group was observed.

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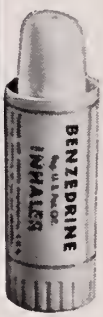
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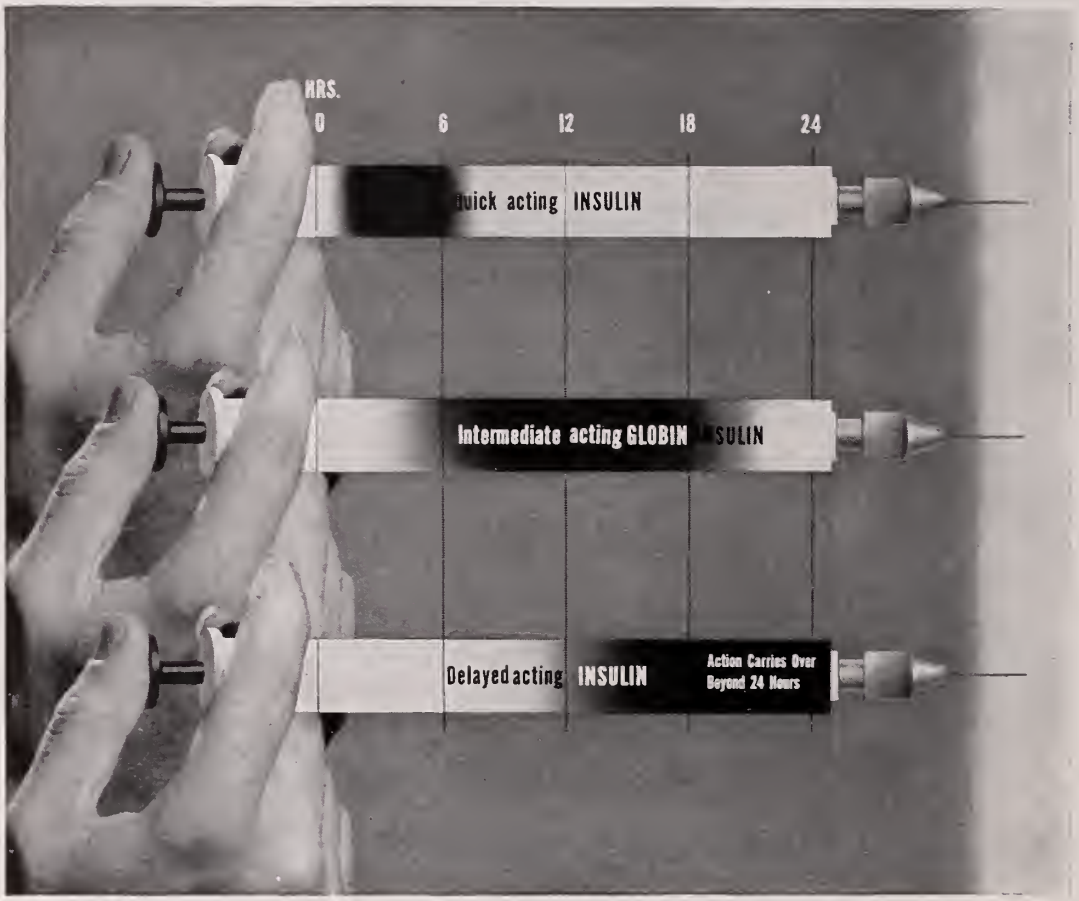
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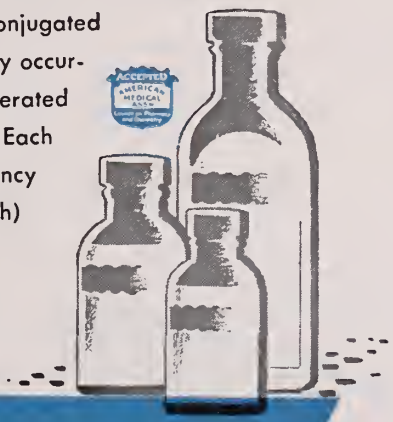
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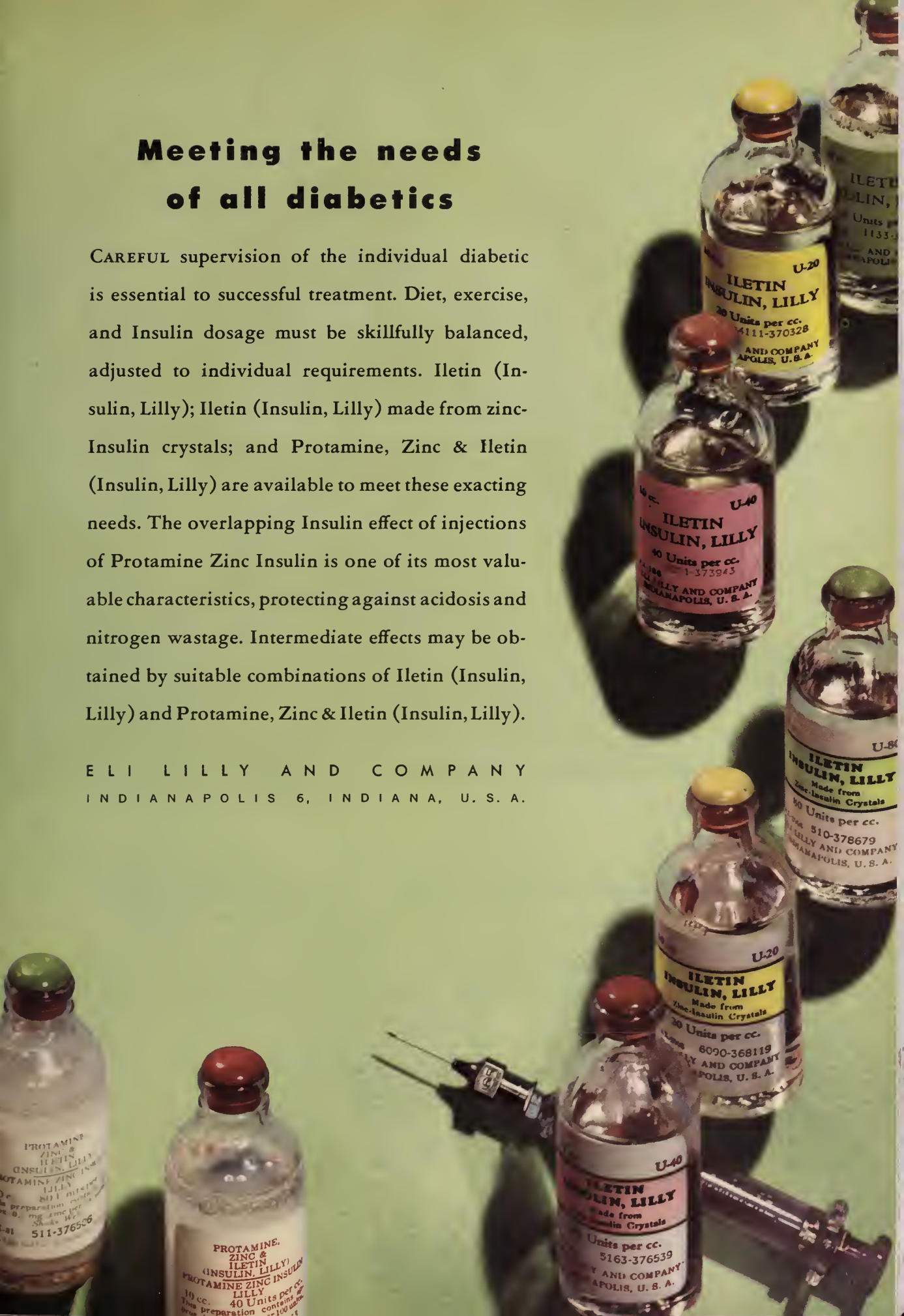
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From childhood's happy hours

FEW PHYSICIANS can define with any degree of certainty the unaccountable impulse that eventually led to the study of medicine. If they were to reach far back into the dusty recesses of memory, they could perhaps recall a time when mother, or sister, or brother was ill and the doctor came to call. They could remember the intriguing instruments which he carried, but more vividly, how fear and apprehension were dissipated with his comforting assurance. From the shadow of such an experience came many physicians of today.

The will to serve sometimes has been an inspiring influence to industrial, as well as to professional enterprises. In order to withstand the pressure of changing times, a business as well as a profession must be anchored to something basically fundamental. It must have a mission to perform, an objective high in the ranks of worthy causes. Just as medical practice has evolved with social and scientific progress, so has Eli Lilly and Company endeavored throughout its seventy years of existence to broaden its sphere of usefulness.



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MULTIPLE TRANSFUSIONS

Lt. Comdr. Orland F. Smith, mc, usnr

The Author. *Lt. Comdr. Orland F. Smith, MC, USNR, of Pawtucket, R. I. Transfusionist and Junior Assistant Surgeon, Memorial Hospital, Pawtucket; Assistant Surgeon, Out-Patient Department, Rhode Island Hospital, Providence.*

The end of the war and the caution in most lines of endeavor that attends it is again beginning to manifest itself in many clinical fields. This caution, coupled with the tendency of physicians and surgeons, both military and civilian, to pause and take stock of the vast number of reports, lectures and papers compiled during the war has been anticipated. Two months after the shooting has stopped have already passed and the war is beginning to become extremely remote in the minds of the civilian doctors who so capably took up the tremendous burden created by a military personnel demand. It is equally remote in the minds of many military surgeons. The race to return to "normal" as the present generation has learned to accept it will unquestionably slow the progress of gains already made, and the more critical evaluation of some procedures will necessarily ferret out the exceptions that prove the rule.

The development of multiple transfusions as a safe clinical procedure for the family doctor has been one of the outstanding contributions since the onset of the war, and already bids fair to find a position close to the top of the list. Many reasons will be pointed out to prove that the use of large quantities of blood by transfusion is unsafe. For a better evaluation of these forthcoming discussions, I wish to present the results of over 60,000 cc. of blood, plasma, or cells to a group of thirteen patients. The average number of transfusions was 10.4 per patient. As can be seen in the accompanying table, all blood types were represented. The least number of transfusions to any one patient in this group was three, and the greatest number thirty-three. Of the entire group, only two received less than seven transfusions.

A discussion of the various diseases and injuries requiring treatment by transfusion does not come within the scope of this report. The amount of blood given and the decision to transfuse was made in each case early after admission to the hospital. The type of transfusion first given in most cases was whole blood. That this is the transfusion of choice is adequately demonstrated in that 49,000 cc. of the entire amount fell into this group. A careful evaluation of the blood pressure, pulse and general appearance of the patient still remains the best immediate indication. Laboratory reports of a hemoglobin of below 7.5 grams, a red cell count of below 2,500,000, or an hematocrit below 25 were accepted as the indications for multiple transfusions, regardless of the admission diagnosis. Any one of the three tests will suffice but it has been my good fortune to have all three at very short notice.

In the establishing of a program to give safely numerous transfusions to one individual, all of the pitfalls were carefully considered. The many disagreements found in the literature concerning the pros and cons of blood transfusion for any particular diagnosis were also carefully evaluated. The net result was to prove that the same procedure was effective in every condition where acute or chronic blood loss had occurred. The patient with an active, uncontrolled, gastro-intestinal hemorrhage was treated the same as a patient with epistaxis or severe bleeding following a compound fracture. Volumes have been written about the bleeding gastric ulcer, and there is still no agreement as to what procedure is proper. Extreme differences of opinion have served to create confusion, rather than correct this particular problem in physiology. I have treated these patients by multiple transfusions in volumes sufficient to replace their lost blood as fast as they could absorb it. Reversal or correction of shock prepares them for surgery, but the case that will not respond to conservative therapy is the well known exception and usually dies on the operating table.

In this group of patients no less than 500 cc. of

continued on next page

whole blood was considered as an adequate transfusion at any one time. Repeated transfusions of small amounts of blood, in my opinion has little to recommend it. The danger of blowing out the clot has been the main argument for the small and frequent amount. The classic theory of blood coagulation so universally accepted is in serious conflict with this postulation.

Donors with the same type blood as the patient were chosen in all cases. "Universal donor" blood was not used except to the type O patient. The "Universal Donor" still remains a cause of many undesirable immediate and remote complications, in spite of recent reports concerning the preparation of safe universal blood. In many instances "banked blood" was used, but no transfusion of blood more than 72 hours old was given. All of the blood, plasma and cells had been citrated, and the largest amount of whole blood given in 24 hours was 5000 cc. In this particular patient, two different donor bloods were given at the same time with no ill effects. There were several other instances in which three or more transfusions were given within the first few hours after admission with no reactions.

The preparation of the cell suspension was completed as has been recommended by other writers, the same care being taken to use cells which had been withdrawn not more than 72 hours previously. Although 4100 cc. of cells represents a relatively small amount to include in any report, the obvious benefits observed in those few patients makes it of value to mention.

In the preparation and cross matching tests performed on each patient, particular care was given to cross match only bloods of the same type. Both warm and cold agglutinins were tested for in each patient and considered carefully before the second transfusion was started. By these latter procedures, several incompatibilities were discovered in bloods that otherwise appeared compatible in cross matching at room temperature, and the donors promptly eliminated. The time consumed in taking this extra precaution is comparatively negligible. Among the major causes of intra-group reaction now known is the Rh factor, and although the percentage of positive cross matching tests is admitted to be small, any effort to prevent a reaction makes it worth while.

The necessary time to complete these tests would rarely exceed the time consumed in completing the first transfusion. Although no female patients are included in this report, the association between severe transfusion reactions and pregnancy makes careful testing even more important. The literature during the past year has presented several case reports wherein anti Rh substance has survived for many years following the last pregnancy. In my own experience, I have observed a non-fatal hemolytic reaction in a 65 year old Rh negative female, transfused with blood from her Rh positive, 32 year old son. She was later transfused with Rh negative blood without reaction.

TRANSFUSIONS

Case No.	Type	Number	Volume (cc) Blood	Plasma	Cells	Reactions Number	%	Mortality
1.	O	11	3500	250	1200	0		0
2.	O	3	1500					
3.	A	13	6500					
4.	A	7	2750		500			
5.	B	9	2500	500	700			
6.	O	7	3250			2	28.5	
7.	O	5	2000		500	5	100	
8.	O	33	5500	5600		1	2.9	
9.	B	7	3500					
10.	A	10	4500	250				
11.	O	10	5000					
12.	O	11	4500	500	1200			
13.	AB	8	4000					
Total		134	49,000	7100	4100	8	5.96	0

There were eight reactions of a mild nature in the entire group, or a percentage of 5.96. All types of reaction were recorded. This percentage was increased considerably by the fact that one patient had a mild reaction characterized by a temperature rise not exceeding 101 degrees, a chilly sensation, and generalized urticaria after each of 5 transfusions. The cause was not definitely determined, and repeated tests proved none of them to be hemolytic. The remaining reactions observed were likewise non-hemolytic. From the entire group it is reasonable to state that multiple transfusions of blood, plasma or cells will produce reactions in 1.5 to 2% more patients than the single transfusion. Although no hemolysis was demonstrated in any of the reactions, each was treated immediately by the injection of 5 grams of Sodium Lactate. Sodium Citrate in the same amount has been recommended as a means of immediate alkalinization of the urine, and in spite of its rapid oxidation in the blood stream has caused several untoward reactions in my hands, which were as disturbing to me as to the patient.

In any discussion of the end results of multiple transfusions, the physio-chemical changes always enter. The most conspicuous change in this field occurs in the blood urea nitrogen, but the elevation in no instance reached an alarming figure in this group of cases. The urea nitrogen determination in case number 8 reached a peak of 49 mgm./100 cc. on the fifth day after admission, but fell rapidly to normal at the end of ten days. This was the highest recorded in the entire group, which would seem to satisfy me that the blood urea elevations may be disregarded entirely if proper preliminary crossmatchings are made. Red cell fragility will not change materially in citrated blood that is used prior to the expiration of 72 hours. In each of these

patients a quantitative Van den Bergh test was performed on the 7th day following the last transfusion, and in each case was reported as too low to read in the colorimeter. Red cell counts were maintained at a consistently high level with only minor reductions at the end of one week.

In conclusion, the consideration of multiple transfusions must call to mind the possibility that too much blood can be given. Over loading the circulation must never be overlooked, either with blood, plasma or cells. I might add that the patient in whom such a phenomenon appears is always the one for whom more blood or plasma appears indicated. Increased pulse rate, cyanosis, respiratory distress and cardiac arrythmia are the important symptoms, and may end in death if venesection is not employed.

Summary

1. One hundred and thirty-four transfusions to thirteen patients are reported.
2. Reactions occurred in 5.96%.
3. The use of donor blood of the same type as the patient is stressed.
4. Repeated transfusions of the required amount of blood at short intervals is a safe precaution.
5. Whole blood remains the transfusion of choice where whole blood has been lost.

CASE REPORTS

Case Number 1.

Fifty year old male admitted to the hospital with a history of vomiting a large amount of blood on two occasions before admission. Red blood count before transfusion was 3,660,000. For the first six days after admission he vomited between a pint and a quart of blood each day. In spite of multiple transfusions daily his cell count dropped to 1,330,000 on his tenth hospital day. During this time he had been given 3500 cc. of blood. Bleeding stopped on his 10th day. During the second week he was given red cells alone for a total of 1200 cc., and an additional 1000 cc. of whole blood. His grand total of transfusions was 500 cc. of plasma, 4500 cc. of whole blood, and 1200 cc. of cells without reaction within 15 days of his original hemorrhage. X-ray studies at a later date failed to reveal any source of bleeding.

Case Number 2.

Twenty-five year old male admitted to the hospital, complaining that he was awakened at 5 A. M. by nausea, and promptly vomited a large amount of blood. This was repeated two times shortly after the original hemorrhage. His bowels moved at the time of his third vomiting spell, and consisted of a large black, watery stool. On admission his red blood count was 1,450,000, hemoglobin 4.5 grams and hematocrit 14. He received a total of 6500 cc. of blood by transfusion in 500 cc. amounts and had no reaction until his 10th transfusion, which was given fifteen days after his initial attack of vomiting. We were unable to explain this reaction, but suspected it to be of pyrogenic origin. Tests for hemolysis were made and found negative. His Rh reaction was positive. He received three transfusions later without any ill effects or reaction. X-ray studies later revealed a healed duodenal ulcer. His blood chemistry, cell volume, hematocrit and hemoglobin remained at normal levels for the remainder of his hospital stay.

Case Number 3.

Forty-six year old veteran admitted to the hospital complaining of passing blood by rectum of two weeks duration. He had been having pain in his abdomen for nine months. He followed a diet for a while and then began to drink to treat a bad cold. He gave the history of fainting a few times during the two weeks prior to admission, and had lost thirty pounds in the preceding three months. Physical examination was essentially negative. His initial red blood cell count was 1,590,000, hemoglobinn 4.25 grams, and hematocrit 16%. He was given a total of 2500 cc. of blood in 500 cc. amounts before his blood volume reached a normal figure. This was given over a period of three weeks. He was operated upon six weeks after admission, at which time the X-ray report of a lesser curvature ulcer was confirmed by subtotal gastrectomy. Postoperatively he was given 1000 cc. of blood and 500 cc. of plasma. At no time was there any evidence of reaction or cell destruction.

Case Number 4.

Thirty-seven year old male admitted with a history of right sided nasal hemorrhage occuring several times prior to admission. Red blood count on admission was 1,730,000, hemoglobin 6 grams, and hematocrit 18%. He was given 750 cc. of whole blood in 500 cc. amounts, and 500 cc. of cells during the first six days after admission without reaction. The bleeding was controlled by packing. He failed to show any sign of cell breakdown, and was discharged on his tenth day with a normal blood volume.

Case Number 5.

Twenty year old male admitted following a compound fractured femur sustained two days before admission while on duty at sea. His red blood cell count on admission was 1,350,000, hematocrit 12% and hemoglobin 4 grams. He was given a few plasma transfusions aboard ship, and during the first thirty-six hours after admission he was given 5000 cc. of whole blood. In this patient it is inter-

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MANIFESTATIONS OF DISEASES IN THE MOUTH*

PAUL E. BOYLE, D.M.D.

The Author. *Paul E. Boyle, D.M.D., of Philadelphia. Professor of Oral Pathology, The Thomas W. Evans Museum and Dental Institute, School of Dentistry, University of Pennsylvania, Philadelphia, Pa.*

THE title of this evening's paper is sufficiently broad to allow an approach from a number of points of view. I propose, first, to consider the point of view of the physician examining the mouth of his patient, then, that of the dentist. Subsequently, I wish to discuss the merging of the two points of view; the physician and dentist discussing together the relation of disease in the mouth to the health of the patient. Finally, I should like to present the point of view of the research worker concerned with problems pertaining to diseases of the teeth and their attachment tissues.

The physician traditionally looks at the tongue of his patient during the physical examination. He notes the conditions of the teeth, if present, glances at the gums and palate and passes on to the throat and beyond the domain of the dentist. Someone has described modern medical diagnosis as diagnosis by exclusion. The well trained physician is familiar with the appearance of healthy soft tissues and is alert to notice deviations from the normal. He will look at the lips for the rhagades of congenital syphilis, the cheilosis of riboflavin deficiency or other signs of disease.

The tongue is remarkable for the number of indications it may give of the physical condition of the patient. Beside congenital malformations, which are rarely seen, there are muscular tremors and incoordinations which may indicate central nervous system disturbances or thyroid gland hyperfunction. Then there are the common coatings of the tongue associated with fever or gastrointestinal disturbances. Microscopically these coatings are the result of retention of cornified cells on the tongue papillae. This promotes the multiplication of bacteria to enormous numbers which often cause a disagreeable odor.

Hypertrophy of the papillae may in rare instances give rise to the condition called black or hairy tongue. Black tongue in dogs has been associated with Vincent's infection secondary to nicotinic acid deficiency, but the condition in man is apparently unrelated to this deficiency.

The fungiform papillae, when red and swollen, cause the "strawberry tongue" characteristic of scarlet fever.

A partial or complete atrophy of the papillae is found in the smooth tongue of pernicious anemia. Rather similar appearances may occur in pellagra. Localized and wandering patches of atrophy are found in geographic tongue. In swine, similar wandering lesions occur in pantothenic acid deficiency.

The palate may be the site of gumma or tuberculosis. Tumors of the palatal mucous glands, while not as common as tumors of the parotid gland, are not rare.

The gums are of interest in that metallic deposits there may be the first indication of lead or bismuth poisoning. Sulfides of these metals form in the connective tissue just below the free margin of the gingivae and show through the epithelium as a blackish stippling.

The gums and other oral mucous membranes may show early and distinctive signs of Addison's disease, scurvy, or Vincent's disease. Koplik's spots may be the earliest diagnostic sign of measles and the mucous patches of secondary syphilis may be first recognized in the mouth. Leucoplakia of the oral mucous membranes is looked for and if found, is viewed with suspicion as a possible site of malignant growth. Irritations from tobacco and from rough teeth or dental appliances assume an important place in the etiology of leucoplakia and of carcinoma. The latter may arise in irritated areas with or without the previous presence of leucoplakia.

The teeth themselves are, I believe, terra incognita to most physicians. The fact that Hutchinsonian teeth may indicate congenital syphilis is probably part of the background of knowledge retained from medical school days, but the more general principle that developmental defects of many types are accurately recorded in the structure of the teeth is less well known. Mottling of the teeth due to excess fluorine in the drinking water during the time the teeth are forming is a common clinical finding in some parts of the United States, but fortu-

*Presented before a joint meeting of the Providence Medical Association and the Rhode Island State Dental Society, at Providence, R. I., November 5, 1945.

nately or unfortunately, it is rare in New England. Almost the only individuals in the city of Providence exhibiting fluorosis of the tooth enamel will be those born and spending the first few years of life in certain parts of Italy and Sicily. These patients, as is now well known, show almost complete immunity to dental caries, although their children born and raised in this country are often very susceptible to caries. This fact was once attributed to a change in the nutritional quality of the diet, but the incorporation of fluorine into the enamel appears at present to be more significant.

Tooth decay, unless advanced, is likely to escape the attention of the examining physician. Crowns, especially gold crowns and extensive bridges, arouse suspicion of the presence of foci of infection. Porcelain restorations, which may be quite as great a source of danger to the health of the patient, will probably not be detected.

Loosening of the teeth and pockets about the teeth from which, upon pressure, pus exudes will indicate a late stage of the common disease entity, pyorrhea alveolaris. The importance of this disease as a portal of entry of microorganisms into the blood stream is not as generally recognized as it should be.

Loosening of the teeth due to processes in the underlying bone such as Hans-Schüller-Christian disease, Paget's disease, cysts or tumors, is a possibility that should be kept in mind. The enlargement of the lower jaw and spacing of the teeth in adults is characteristic of acromegaly.

The list of signs of disease occurring in the oral cavity might be greatly lengthened. In general, however, it may be said that the physician is seaching for deviations from the normal in the oral tissues which may serve as signs of systemic disease. Such signs are extremely rare among well people but are more numerous among the sick and, when found, may provide important leads toward the diagnosis of disease. Secondly, the physician is concerned with the teeth as foci of infection which may contribute to the ill health of his patient.

The dentist looks at the mouth of the patient primarily from the point of view of repair. This is essentially the point of view of the surgeon diagnosing and planning repair of a hernia, for example. It is in no sense derogatory. The dentist, like the otolaryngologist, is highly trained in the recognition of signs of disease and in the surgical treatment of that disease. The greater part of his practice is devoted to the treatment of tooth decay or its sequellae. His patients are not sick, generally speaking. No clear correlation has been made between good health and immunity to dental caries. Cleaning and polishing teeth to prevent the initiation of tooth decay has proven to be of limited effectiveness. Diet has been shown to be of great significance during the formation of the teeth. In general, metabolic disturbances which adversely affect bone structure have similar deleterious effects on tooth structure which is being formed at the time. Tooth decay, however, attacks the most perfectly formed teeth almost, if not quite, as readily as hypoplastic teeth. There is ample evidence that diet is of great importance in building healthy bodies and maintaining resistance against infection. The evidence that diet is effective in controlling dental caries is somewhat less conclusive. The publications of Mellanby, Boyd, Howe, and their co-workers, indicate, however, that an adequate diet is of importance in lessening the incidence of tooth decay and of reducing its rate of progress. The influence of sweets on the promotion of dental caries has received much attention. Sugars and starches have been implicated both for prematurely satisfying the appetite by supplying calories without the proteins, minerals and vitamins necessary for a well balanced diet and for promoting the activity of acid production by bacteria on tooth surfaces, thereby dissolving the enamel and opening a pathway for the progress of tooth decay.

Nevertheless, the majority of dentists feel confident that early detection of tooth decay, complete eradication of the affected tooth structure and replacement by a filling is the only really effective method of dealing with dental caries. Even though the use of fluorine, the impregnation of enamel with nitrocellulose, or other non-surgical procedures should eventually prove successful in drastically reducing tooth decay, the dentist is all too well aware of the enormous amount of reparative work necessary at the present time. It is quite understandable then, that his attention should be primarily focused on the detection and the treatment of dental caries and of the replacement of teeth lost chiefly as the result of dental caries. Mechanical considerations are of great importance in dental restorations. Engineering is as important as surgery for the success of dental restorations. Without technical competence, good dentistry is impossible. Esthetic considerations are also important. Without modern dental care most of us would be sorry looking individuals. The functional efficiency of the teeth in mastication as a step in the process of digestion, is not to be disregarded.

All this makes it understandable that the dentist should focus directly on the teeth and the necessary repair work to be found there. This is by no means all of dentistry, however. The dentist is concerned with the growth and development of the dental arches and the relation of the teeth of one jaw to those of the other. Much of the responsibility for treatment of mal-development and mal-arrangement of the teeth has been delegated to orthodontics, one of the great subspecialties of dentistry.

continued on next page

The growth of the face and the part the teeth play in that growth are a fascinating study. The influence of genetic and of environmental factors, including use, habits and diet, has received considerable study in an attempt to better understand the normal development of the dental arches and deviations from the normal. The use of mechanical forces in stimulating the growth of bone and thereby moving the teeth into normal alignment, has reached a high point of clinical application in a field which is, in essence, dental orthopedics.

Another major subdivision of dentistry is oral surgery. Surgical principles apply here as in any other field of surgery. The extraction of teeth is an important part of the work of the oral surgeon. It is surprising that in most instances a large gaping wound left by the removal of a tooth heals with only occasional complications. The use of the blood plasma products in such wounds appears to be a very promising means toward control of postoperative hemorrhage and toward promoting repair.

The extraction of teeth is by no means the entire field of oral surgery. The ends of root-treated teeth may be amputated, cysts and tumors removed, etc. The plastic surgeon is often concerned with the face and many outstanding plastic surgeons were primarily trained in dentistry. Most of these men have, in addition, medical training so that this is one region where medical and dental practice often merge.

There are a number of lesser fields in dentistry where specialization is developing, such as endodontia, periodontia and prosthodontia. Specialization in very narrow fields tends to develop knowledge and technique in these fields. The shortcomings of over-specialization are clearly recognized and there is a growing realization of the need for broad training for competent general practice, in dentistry as in medicine.

The problem of periodontal disease deserves special mention since it is, next to caries, the greatest cause of loss of teeth. The gingival attachment, like the nail bed or the hair follicle, is a point of low resistance to infection. Gingival inflammation leads to detachment of the soft tissues from the tooth, pocket formation, resorption of alveolar bone and, eventually, exfoliation of the tooth. Local factors such as calcareous deposits, impaction of food, faulty dental restorations and excessive occlusal forces are important in localizing periodontal disease. There has been recognized a systemic factor primarily affecting the bone and soft tissues of which we shall have more to say later.

The dentist tends to concentrate on local factors in the treatment of peridontal disease. He removes the calcified deposits, corrects the mechanical defects which allow impingement of food, relieves the excessive occlusal forces and institutes massage and rigorous cleanliness on the part of the patient and in a fairly high percentage of cases the disease becomes arrested or clinically cured. The search for specific bacterial agents has not been successful. The influence of endocrine disturbances, dietary deficiencies, etc., has received considerable attention from some dental investigators and further progress along such lines is hoped for.

The lesions that were enumerated in the first section are infrequently encountered in routine dental practice. The dental practitioner has the advantage of seeing patients who are, generally speaking, in good health. He may be, however, the first to detect signs of diabetes, leukemia, carcinoma, etc., in the oral cavity. His record of referring the patient to the physician for further diagnosis and treatment is, on the whole, excellent.

This brings us to a consideration of cooperation between the physician and the dentist in their joint handling of a patient. One instance has just been mentioned, the case in which the dentist notices some unusual sign of disease, perhaps in the mouth of a patient whom he has cared for over a period of years. The reverse is when a physician detects evidence of dental disease and refers a patient to the dentist for its treatment. In such cases, the physician has in all too many instances, assumed superior knowledge and has not hesitated to order the removal of teeth which he regards as infected. Comroe, Collins and Crane,[1] in a book which was written for dentists, but by which many physicians might profit, write as follows on this point :—

"The authors feel very strongly that still closer cooperation and understanding must exist between internist and dentist. The dentist must be regarded by the internist as a consultant in the same sense as is the otolaryngologist, the roentgenologist, or the dermatologist. The physician must not tell the dentist what should be done in the mouth, but should carefully consider the dentist's report concerning his patient. The dentist should not merely have the patient return to the internist, with the x-ray films of his mouth, as many medical men have practically no training in the interpretation of such films. The complete report from a qualified dentist is extremely useful to the physician."

"Dental focal infection usually implies periodontitis (pyorrhea alveolaris) or periapical infection. Unfortunately, most medical men know very little concerning the teeth and their disorders ; however, they do not hesitate to inform the dentist that certain teeth must be extracted.

The dentist must be considered as a consultant rather than as a mechanic. Dentists are frequently able to save important teeth and to eradicate infection by means other than extraction. Both clinical and roentgenologic examinations of the teeth

should be made as the roentgen-ray may reveal the bony appearance to be fairly good when the condition is much worse clinically; on the other hand, roentgen examination may disclose lesions in a clinically 'clean' mouth."

The dentist has also erred, most frequently I think, in giving dietary advice which may be ill founded. The dark bread enthusiasts have aggravated many cases of colitis, for example. The dentist has an inferiority complex, if I may use that convenient cliché, regarding his medical knowledge and the physician perhaps has one too, regarding his understanding of dental problems. They may each misunderstand the other to the detriment of the patient. Assemblies such as this one tonight are an indication that they may meet on common ground and learn from each other.

Let us turn now to the point of view of the research worker concerned with dental problems. There are many aspects of investigative work which might be used as examples. The story of the recognition of fluorine as the cause of mottled enamel and later as a factor in reducing susceptibility to dental caries is a most interesting one. The developmental defects during tooth formation and their record of endocrine and nutritional disorders is another. I have chosen to present a very minute problem in enamel and dentin formation involving academic questions primarily and then to discuss the application of this work to the clinical problem of periodontal disease.

By a series of brilliant investigations, Wolbach and Howe[2,3] demonstrated that vitamin C deficiency, scurvy, is characterized by inability of cells of mesenchymal origin to produce and maintain intercellular matrices. This effect was clearly shown in connective tissues of many types including the dentin of the teeth. In 1934, Fish and Harris[4] described changes in the enamel-forming cells in complete scurvy but not in subscurvy. Their conclusion that "the failure of normal enamel formation, to which we find that vitamin C deficiency gives rise, may be of significance in the causation of human caries" attracted considerable notice.

You will remember that enamel is an epithelial tissue derivative and according to Wolbach and Howe, epithelial tissues are secondarily, but not primarily, affected in scurvy. It therefore, appeared important to investigate further this apparent failure of enamel formation in vitamin C deficiency. Briefly, we found that not only complete scurvy but various degrees of partial scurvy were accompanied in many instances by areas of defective enamel formation. These areas were, however, always sharply localized and related to damage to the overlying enamel organ. The greater part of the enamel was always formed in practically normal amounts regardless of the degree of vitamin C deficiency.[5] The rate of dentin formation, however, was found to be directly related to the amount of vitamin C given the animal.[6] The areas of defective enamel were therefore concluded to be due to failure of the connective and bony tissues which attach the tooth to its socket. The enamel defects found in scurvy were considered to be secondary to changes in the connective tissues, as in other parts of the body. The hypothesis that scurvy may be of significance in the causation of dental caries appeared untenable because of extensive clinical and laboratory data as well as from our observations that the enamel was not primarily affected in vitamin C deficiency.

All this, I am sure you will agree, is very academic. This minor controversy served, however, to focus our attention on the mechanisms by which the teeth are suspended from the jaws and led to observations on the systemic type of periodontal disease which have been regarded as of clinical significance.

In discussing pyorrhea alveolaris or periodontal disease I mentioned that it was generally classified into two main types: one, a local type starting at the gingival crevice and the other, a systemic type involving first the bone and deeper soft tissue attachment. In the second type, the teeth become loose and migrate to abnormal positions, largely under the influence of occlusal stresses. The development of pockets and suppuration is usually a late complication and the gingival tissues for long periods may appear healthy upon ordinary clinical examination, although by x-ray the alveolar bone is greatly rarefied. Excessive occlusal forces of opposing teeth have been regarded by some as the etiologic factor. Efforts to produce the disease syndrome in dogs by the application of excess forces have been completely unsuccessful. In the partially scorbutic guinea pig, however, the essential features of the systemic type of periodontal disease were recognized. The important characteristics may be summarized as inability to withstand functional stress. Vitamin C deficiency therefore, has made available an experimental method of producing one type of pyorrhea alveolaris.[7]

Finally, I wish to say a few words about dental enamel. This tissue is the only normally calcified epithelial tissue in the body. By weight it is approximately 97% inorganic substance. It is so hard that it will give sparks when struck with steel. Microscopically it is composed of rods which are 5-6 microns in diameter, that is, approximately 5000 of them laid side by side, would measure an inch across. Because they are so hard it is extremely difficult to make sections of them which can be examined under the ordinary microscope. After treatment with acid it is even more difficult to retain structure which can be examined micro-

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THE MEDICO-DENTAL RELATIONSHIP*

ALBERT L. MIDGLEY, D.M.D., SC.D.

The Author. *Albert L. Midgley, D.M.D., Sc.D., of Providence. Chairman, Committee on Dental Research, American College of Dentists.*

The time has come when the relation of dentistry to medicine should immediately be recognized as a genuine copartnership in the service of the public health.

The purpose of this essay is to focus attention upon the logic, the duty, the necessity of facing resolutely the fact that the healthy functioning of the human organism depends upon the effective care of *all* its parts, and to urge such a correlation of the ideals, policies and professional activities of medicine and dentistry as will promote the highest degree of well-being for both medical and dental patients. There is abundant reason for the ever-growing conviction that the public interest and welfare demand a more practical and uniform cooperation between the two professions, and that individual practitioners cannot fail to benefit by a cordial interchange of ideas and observations.

Knowing what we assuredly do know about the importance and usefulness of the united services of medicine and dentistry, their unalterable responsibility for the maintenance of complete physical health, their manifest duty in regard to the promotion of cooperative research and broader, more comprehensive teaching,— and comparing with this the little that we have actually done to develop a consistent, progressive and truly generous program of *national* scope both in professional education and in practice, must we not truthfully accuse ourselves of backwardness and indecision?

The potential value of the medico-dental relationship never has held and does not now occupy any conspicuous place in the mind or the conscience of either profession. Why must the individual genius, the cumulative knowledge, energy and experience, the organized power and influence which have accrued to both professions be still confined to separate channels, when one strong current would carry them both forward to regions of broader vision and finer achievement? What can be done *now* to release this magnificent power?

*Presented before a joint meeting of the Providence Medical Association and the Rhode Island State Dental Society, at Providence, R. I., November 5, 1945.

Since the scientific world accepted the fact that diseases of the mouth and disorders of the teeth are grave sources of danger to the general health, the logical objective of enlightened leaders in dentistry has been a professional status in all respects equal to that of medicine—equal in educational opportunity, in united effort for scientific advancement, in altruistic acceptance of responsibility for safeguarding the public health, in freedom from all taint of commercial influence and mercenary practice, in proud and deserved enjoyment of the respect and appreciation of the community at large.

It is neither necessary nor practicable for the physician to be a dentist or the dentist to be a physician; it is necessary, and must therefore be made practicable for the two professions to cooperate in both education and practice, since science has decreed that they must henceforth consider themselves jointly responsible for the physical well-being of the private patient or the civic group for whom their services are demanded. Physician and dentist must therefore meet each other with a mutual respect based upon an equal degree of intellectual culture; a common knowledge of the biological facts which underlie their practices; and a simple recognition of the economy of effort which cooperation will ensure, since their problems of prevention, diagnosis and cure have much in common.

Since the acceptance of the focal infection theory, neither profession is complete in itself or competent to take over the functions of the other: but each is in duty bound to collaborate with the other in this common service, and should find itself impelled toward a common sympathy and understanding. In both professions the primary objective was formerly to cure; in both it is now to prevent; and *basic training* is therefore similar for dentistry and for medicine—a fact which naturally tends to friendly exchange of ideas and discoveries. The actual processes of arresting dental disorders, conserving dental structures, maintaining dental health and dental functions, preventing or postponing dental infections, belong to the practice of dental science as separate from medical science and require the dentist's special knowledge; but the possibility of focal infection, and the obvious fact that disease in one part of the body

may be the cause of or related to disease in other parts, must always suggest a pooling of knowledge and experience among physicians and dentists.

The complexities of such collaboration between medicine and dentistry need not be greater than they would be if dentistry were a coventional oral specialty of medical practice instead of an autonomous profession; and yet the potential reciprocal value of such an improved relationship has been, and continues to be, very slow to impress itself upon the consciousness of either profession. Instead of having a comprehensive program for the performance of common duties and to meet similar hazards (such as panel medicine and conveyor-belt methods of treating carious teeth), neither profession has received the necessary impetus to join the other effectively in a coordinate relationship to assure scientific treatment for the health of the human organism as a *whole*.

Dentistry is well prepared to receive and to confer the benifits of special knowledge, skill and experience in a program of coordinate health-service with medicine.

Modern dental education has been preparing the dental profession to meet its part of this obligation; but public understanding, recognition and support have not kept pace with the progress of dental science and dental professional ideals. For example, the public, which relies upon the judgment of its physicians and dentists, may not perceive that the principles of the basic sciences and their application in dental practice are definitely and positively in conflict with dental service of a purely mechanical nature, if that service is not successfully adapted to its possible effects upon living tissue. The dental schools are sending forth graduates who have been faithfully taught the same biologic sciences which form the basis of medical practice, and who may be expected to remember and apply their teachings as well as physicians do. Dentists owe it to the public and to themselves to emphasize this important fact as a feature of dental health-service, thus also demonstrating the close relationship between dentistry and medicine.

Having experienced for more than a century the tireless ambition, progressive improvement and inherent strength of our separately-organized profession, we beleive that dentistry's continuance as an autonomous division of health-service is at least not inimical to the public welfare. The recent failure of the expensive and much-publicized Harvard Plan of dental-medical education, which so soon confirmed the prediction that it would prove abortive, adds force to the prevalent opinion that attempts to disturb dentistry's autonomy are unjustified on any ground whatsoever. This view is not only held by dental leaders in education and practice, but endorsed by many educators outside of dentistry who have been observing the trends, experiments and acknowledged accomplishments of the past quarter-century.

All these academic attempts to merge dentistry into medicine have failed thus far; yet they have a significance which dentistry cannot afford to ignore since they indicate that the dental profession and its procedures are being subjected to critical examination by educators, philanthropists, and others, and also that close coordination of medical and dental health services, in education and in practice, is assumed by such persons to be natural and desirable.

All the newly-accepted responsibilities of dentistry, the raising of academic standards, the liberation of the dental press, the sponsoring of dental research, the persistent inquiry into ways and means of promoting steady growth in professional character, opportunities and attainments, were tending toward one natural goal—the honest interpretation and dutiful performance of dentistry's part in the maintainance of health. In the process of defining dentistry's part, it was inevitable that medicine's part, and the possibility of some *unfilled gap between the two,* should come up for consideration; in short, that dentistry's relation to medicine should become a problem of major importance, both in educational policies and in professional practice. Each portion of this problem has now received intensive study, and a considerable body of material has been accumualated to form the basis for a program of medico-dental cooperation. For such a program dentistry believes herself to be well prepared; on her part, the ideal of an acceptable medico-dental relationship is ready to take shape as a living and beneficent reality.

Dentistry has no long-standing prestige as a health profession comparable to that of medicine. The right kind of dental service in hospitals, which dentistry has been endeavoring to bring about, is still a new thing, of which comparatively few practising dentists have had any experience or advantage. There are still elderly practitioners (both in dentistry and in medicine) with little or no modern training in the basic sciences; and others, middle-aged, not sufficiently trained to utilize the sciences effectually in their professional procedures. The young graduates in dentistry, having the full benefits of modern training and environment, are confronted with current economic ideas and the temptation to over-extend through deputization some phases of the technical procedures of dentistry. The proposed medico-dental relationship should stimulate a wholesome rivalry with physicians in scientific achievement and advancement, thus minimizing the danger of impairing dentistry's professional autonomy.

With a common educational background, physi-

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cian and dentist will face their opportunities for public service in a spirit of mutual helpfulness, such as that already manifested by the American Medical Association in its recommendation of dental service in the hospitals. This trend reveals some of the joint responsibilities of physicians, dentists and their professional organizations in coordinating their activities with those of universities, hospitals, infirmaries and civic institutions.

Have you not the opportunity, here, to think and act so that the professional activities of common concern and interest to the physician and dentist are conducted in a coordinated program? Here and elsewhere it is but natural that the two coordinated divisions of health service should combine their forces and unite their interests in the common cause, maintaining a just balance in their relationship, guarding against undue interference, but above all making sure of their combined effectiveness in meeting both opportunities and obligations. Medical and dental science, medical and dental service, advancing together, expecting each other's assistance in all phases of activity, will ensure the utmost in professional growth, opportunity and accomplishment.

We have the best of reasons to believe that this ideal of association and cooperation is shared by the medical profession. Dr. Sydney R. Miller—Fellow of the American College of Physicians, Associate in Clinical Medicine, Johns Hopkins University, Associate Professor of Medicine, University of Maryland, Past-President of the American College of Physicians—speaking at the New Orleans convocation of the American College of Dentists (1935) said in part:

"No longer can there be intelligent doubt that public interest will not be best served unless there is interdependence and mutual respect between the medical and dental professions. Both groups need to understand each other better and learn how they can be of mutual assistance in dealing with the problems of disease. . . . Fortunately for all of us, and particularly the public, the practices of dentistry and of medicine have been growing steadily closer as experience has demonstrated the unavoidable interrelationship of their problems. . . . More aggressive efforts should be made to demonstrate, to both our professions as well as to the laity, that the medical and dental problems of prevention, diagnosis, cure, education and research possess much in common. Since neither profession is capable of the entire job, it logically follows that intelligent cooperative work is incumbent upon both professions . . ."

In fairness to dentistry's record of achievement, is it not time to seek an intimate medico-dental relationship and to promote a detailed consideration of the form it should take? May I suggest (1) that the problem be surveyed by a committee of representatives from the Rhode Island State Dental Society and the Rhode Island Medical Society, and (2) that this committee make a comprehensive study of all available data on the existing medico-dental relationship and of all available suggestions on what it should be, and present recommendations on how a medico-dental relationship that would be state-wide in scope and content and most desirable in quality could be attained.

The primary purpose of this proposed study, simply stated, should be to collect and coordinate data on all feasible plans for working cooperation between individual physicians and dentists in the promotion of effective health-service in every community, large and small, urban and rural in the State of Rhode Island. The sooner this purpose can be accomplished, the better. Are dental and medical leaders in Rhode Island and the members of the Rhode Island State Dental Society and the Rhode Island Medical Society willing to do their part in the attainment of this objective? If so, *when?*

MULTIPLE TRANSFUSIONS

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esting to note that he was given a transfusion of 500 cc. of whole blood in each arm at the same time from different donors. In addition to the above he was given a total of 5500 cc. of plasma, and another 1000 cc. of whole blood, all wihin seven days of the accident. During all of these transfusions he had one mild reaction which occurred immediately after receiving an intravenous dose of 40,000 units of gas bacillus antitoxin. As he was receiving a transfusion at the same time we do not know which caused the reaction. Three days after admission his red blood count was 5,120,000, hematocrit 49% and hemoglobin 13.5 grams. Following his first week after admission he maintained his blood volume with no evidence of blood destruction. Gangrene developed in his foot and a mid thigh amputation was performed without incident. He received in addition to the blood and plasma, gas bacillus antitoxin in 40,000 unit doses intravenously, and penicillin in 50,000 unit doses intramuscularly at three hour intervals for several days.

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MANIFESTATIONS OF DISEASES IN THE MOUTH

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scopically. One of our handicaps in the study of dental caries is that the initial phases occur in tissue which is most difficult to examine and little is known with certainty of the details of early stages of tooth decay. With the advent of the electron microscope, some progress has been made toward an understanding of the finer structure of enamel. The technique used up to the present time is borrowed from metallurgy. The enamel surface is ground and highly polished. It may then be lightly etched with acid. Following this an impression is taken with a film of a polystyrene and then a silica film is deposited on the impression. The silica film is then examined and photographed in the electron microscope.[8] Quite recently the laboratory of the Radio Corporation of America, located at Princeton, New Jersey, has developed methods of dispersing finely divided material so that it may be examined. Only this past week, following this technique, I have been able to study fragments of enamel rods. The rods themselves are, as I will show you in the lantern slides, resolved into a number of building units. This investigation is obviously in its infancy but it certainly encourages us to speculate on possible future developments.

In summary then, we may say that the physician is primarily concerned with signs of systemic disease as they manifest themselves in the mouth and with dental infection as it may cause or aggravate disease elsewhere. The dentist looks first of all for something that needs to be repaired. He is interested also, however, in the patient as a whole, in the effects of systemic disease on the teeth and surrounding structures and with the teeth as portals of entry of infection. Because of his success in educating patients to report at regular intervals for examination and treatment, he is in a position to detect early signs of disease which in turn may be called to the attention of the physician to the great advantage of the patient. The relation between physician and dentist is most satisfactory when it is on the same basis as that between the physician and the otolaryngologist or any other specialist.

Finally, the investigator concerned with dental disease has a field in which the problems are to a certain extent unique. Progress depends on a greater understanding of the phenomena of disease as manifested in the mouth and is often made possible by developments in other fields. The goal of research in dentistry is the control and prevention of caries and periodontal disease. As this goal is achieved, dentistry will not be eliminated but will continue its development as a specialty of medicine.

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PATRONIZE

JOURNAL

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PAUL C. COOK, M.D.
President of the
Providence Medical Association, 1946

DURING the past years I have heard many addresses made by incoming presidents of this Association, and I have read others which I have not been fortunate enough to hear. In the majority of cases the speaker's mood seems to have been made up of several components—appreciation of the honor conferred upon them, desire to do their best in conditions new to them, and a hope that they would be adequate to their new situation. These reactions seem to me to be normal ones, and I know that I am experiencing them. No man can know this society — its history, its accomplishments, its aims, the members who make up its fellowship—and not be deeply sensible of the honor of being asked to assume its leadership. The feeling of responsibility comes to me as it has to others —as they have done. I ask you to co-operate in the functioning of your society, to keep the officers informed of work that is being done by our members or by others of the profession, a report of which would be of interest at our meetings, and to express your opinions as to the type of programs you wish presented. As full attendance as is possible is desirable at all our gatherings, not alone for the benefits we may derive from the scientific part of the program, and the showing of appreciation and courtesy to the speakers, but also to increase the sense of solidarity and fraternity that should form a worthwhile part of our professional life. Your support of those to whom has been delegated leadership in the legal and business affairs of the Association has been loyal in the past and without question will remain so.

You will all agree with me that we have been fortunate in our leadership this past year. For many years Dr. Clarke has been a vital factor in the medical life of this city. The laboratory is the foundation upon which the efficiency of any hospital rests. Fortunately for the hospital with which he is associated, through his ability, his energy, and his vision, this foundation has been and is still being made increasingly secure and adequate to support whatever structure may be placed upon it in the years of progress that are ahead. Not alone has the hospital benefitted, but also the city and the state. As individual doctors we owe him much for his help in our problems. We are also grateful for his informative and always interesting talks at our meetings. I trust that it will not be long before he favors us again. A friend has been defined as one who knows the worst about us and likes us just the same. No one knows more about doctors than the pathologist who works with them. That Dr. Clarke has worked with us for many years and still was willing to serve us so well as President of this Association is indeed a proof of friendship.

There is a corollary to the air pollution problem which Dr. Clarke has discussed. It is that of pollution of Narragansett Bay. Clear air and clean water are fundamental benefits that unfortunately must be striven for in these modern times in urban areas. During the past few months there has been increasing evidence of public interest in the question. Last year a committee drew up a resolution stating the attitude of the society on the problem. I feel strongly that pollution of the Bay is an important health, recreational and economic problem, and that it is one in which the Providence Medical Association should have an active and continuing interest. I also feel that the opinion of this society should be made known to the proper authorities and to the general public, and that the influence of the Association should be brought to bear on the side of purification of the Bay. To take whatever action they deem advisable toward carrying out these aims, I appoint the committee which drew up the resolution mentioned, Drs. Chase, Cameron and Migliaccio. I am a Rhode Islander by adoption, not by birth, and I assure you that it is not necessary to grow up with Narragansett Bay to appreciate it. There is no need to say much of the benefits that would result from cleaning it up, nor the economic loss and the health hazard of its present state. Those who might gain the most would not be those to whom the Dunes Club, Quonochontaug or Seaconnet are available. The youngsters of Wickenden Street, Fox Point and Federal Hill would profit if the upper bay were so purified that safe bathing facilities could be established within reach of these districts. Providence does not rank very high among comparable cities in recreational facilities—in time this condition could be remedied if the possibilities

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A NEW LEADER

On January first the Rhode Island Hospital began its seventy-eighth year of service to the citizens of this state with a new Executive Director and Superintendent, Oliver G. Pratt. As the largest general hospital in the state and the principal center of medical education and progress, it has done well to obtain the services of an administrator so capable.

During the last fifteen years, as Director of the Salem Hospital, Mr. Pratt not only has increased the usefulness of his hospital to its community but also has effected such cooperation with neighboring institutions that a real medical center was developed there and better medical education and therefore better medicine resulted.

A native of Salem, an alumnus of Massachusetts State College, Mr. Pratt studied in the Harvard Graduate School of Education, served as a Lieutenant of Infantry in World War I and became Director of Salem Hospital in 1931. He is a member of the American Hospital Association, past Vice-President of the American College of Hospital Administrators and past President of the Massachusetts Hospital Association, the Massachusetts Association for Occupational Therapy and the New England Hospital Assembly. He is a member of the Editorial Board of "Modern Hospital" and of the Board of Directors of the Massachusetts Hospital Service Inc. (Blue Cross) and Medical Service (Blue Shield). He also served as Senior Hospital Administrative Specialist of the United States Public Health Service—covering war time appointment as State Hospital Officer for Civilian Defense (1942-1944).

The Journal is happy to welcome Mr. Pratt to Rhode Island. The aftermath of war, with the scarcity of nurses and other shortages, constitutes a problem which is difficult and discouraging to all in the field of hospital management. In the face of this challenge and with the plans for the new hospital building under way he faces a situation in which his professional skill and experience are needed. In leading the way to the establishment of a really great medical center here he has the eager support of the profession.

WHAT'S IN A NAME?

The news bureau of the Railway Express Agency reports the story that recently an air express shipment for Buenos Aires came to the New York agency marked "Hydroxymercuripropanolamide-orthocabossyphenoryacetine". The shipping clerks threw away their dictionary and conferred. The package soon went zooming to its destination labelled "chemical products".

In what is called the atomic age, a time when even the man in the moon is not immune to the touch of radar, the action of these express clerks in reclassifying the title of their problem is most refreshing. Think of the hours they might have expended in research had they not resorted to the simple expedient of descending to the vernacular

continued on next page

to expedite the passage of the package entrusted to their care.

There isn't much doubt that the average man is very appreciative of the scientific contributions in recent years aimed towards bettering his all round existence. But this matter of scientific terminology, invading with increasing freedom the vocabulary of the ordinary man, is certain to tax his restraint against shouting out the cause of basic English. Like the railway clerks mentioned, he has struggled with the question of where to place the accent on sulfanilamide until science came along with a host of sulfa derivatives for common use. Then to add confusion, penicillin, with its first two "i's" offering a challenge to him who would pronounce accurately, emerged from the mold.

The situation can be most serious. It is not like the pedantic problem of whether to adopt the Anglo-Saxon "understand" in preference to the Latin "comprehend". It goes far deeper into the question of human relations. Imagine the embarrassment of the seemingly educated person who is humiliated by the drug clerk correcting his pronunciation of one of the new drugs. Or consider the plight of the pharmaceutical company which might be forced to advertise to the public to buy its brand of "Sulfy" or "Penny" lest the average citizen shy away from the task of pronouncing the official title.

Oh, well, Spring is not far away, and truly a rose is as sweet by any other name. And while American ingenuity continues to survive the problem will probably be met with the skill of the railway clerks who settled for "chemical products" to the satisfaction of all concerned.

SURVEY OF CHILD HEALTH CARE

The American Academy of Pediatrics is conducting a nation-wide survey, on a state level, of health facilities for children in the postwar period. Already this survey is being carried on in North Carolina which was chosen as the pilot state.

It is the first attempt on the part of an organized group of medical men in each state to inquire into its own practices. It is a fact finding study to determine our own strong and weak points in child health care. Every pediatrician and practitioner in the state will be expected to help in this survey.

The survey must include pediatric and general practice, hospital facilities, dental care, nursing facilities—urban and rural, baby welfare activities, state, city and town health functions and social agency facilities.

Questionnaires will be sent in due course and it is hoped that these will be treated with respect, carefully answered and not relegated to the waste basket with advertising material. If all will cooperate, the task imposed upon the executive secretary of the Academy will be facilitated, fruitful and lead to a proper functioning of all child health medical facilities.

The importance of this survey rests on the simple fact that if the members of the medical profession in the State of Rhode Isand cannot set their own house in order, some other agency will conduct the survey and we may or may not be asked to participate in the planning for the future health of children in our own state.

The Maternal and Child Health Act of 1945, S 1318, the so-called Pepper Bill, provides complete medical services for "All mothers and children in the State or locality who elect to participate in the program" regardless of financial status. Under the title children are considered as all individuals from birth to 21 years of age. The age limit of 21 years as expressed in the act demonstrates the fact that this is not a pediatric problem alone but that every physician in the State of Rhode Island will be affected by the stipulations of the act.

The survey will be conducted by Dr. John H. Hubbard with an office in Washington. Dr. Hubbard is a member of the American Academy of Pediatrics and has been appointed by this organization. Each State Chairman will be responsible to him. Dr. William P. Buffum, State Chairman of Rhode Island, will supervise the survey in this state.

THE PRECEDENT IS ESTABLISHED

The action of the Catholic hospitals in Michigan in resigning from the Blue Cross organization recently focuses attention anew on the manner in which a dangerous precedent can be established by a governmental bureau once it is given leeway to establish regulations by administrative law.

In this instance, so we are informed, the trouble stems from a ruling made by the Children's Bureau of the Department of Labor in the administration of the Emergency Maternal and Infant Care program. In allowing funds to the States the Bureau permitted hospitals to make their charges on their per diem operating cost, but it made its own regulation that the nuns serving as nurses, and in other capacities, in the Catholic hospitals, were volunteers and their work was not compensible. Why this ruling was allowed to prevail, even in spite of the fact that the EMIC was presumably a wartime measure, is difficult to understand. But prevail it has.

Now along comes a revitalized Veterans Administration medical and surgical department that seeks to provide the best care for the veteran, and is ready to meet all fair costs for that care. This is no emergency program; it is a long range plan calling for the utilization of available hospital facilities in local communities. The Catholic hospitals offered their assistance and submitted their

complete per diem cost which the Veterans Administration reportedly found acceptable. However, the Bureau of the Budget stepped into the picture to rule that the previous provision relative to the inclusion of the services of the nuns in the operating costs of the Catholic hospital prevails also for the Veterans program.

Perhaps the Catholic hospitals of Michigan should not have withdrawn from Blue Cross. Yet, since the Veterans Administration plans to enter into contracts for the care of the veterans with the Blue Cross which in turn would sub-contract its member hospitals, the Catholic group apparently felt that it had no alternative.

If we are informed correctly of this problem we venture the opinion that it goes far beyond the mere payment of the full per diem hospital cost of the institutions involved. It looms as an issue to determine the scope of bureaucratic authority to establish, by administrative right, patterns that are not consistent with regular community practices. The Catholic hospitals by this recent action have openly challenged the precedent established by the Children's Bureau. Their action will not be without wide support throughout the country.

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MESSAGE FROM DR. PAUL COOK

continued from page 118

of the Bay could be realized. I believe that no state in the Union has received from Nature a more glorious heritage than Rhode Island has in Narragansett Bay. Let us strive to restore it to a better condition, and to keep it a source of health and of pleasure for ourselves and our children.

During the past few years medical practice in Providence has suffered because of the absence of a large percentage of our best men in the armed services. Those of us who have remained have to some extent been forced to make one of two decisions—to limit the number of patients seen or to reduce the amount of time and study given each patient. The results have not been satisfactory to either the patients or ourselves. We have not been able to give the service we would have liked to give. We have been to much tempted to cut corners in our work. As doctors we are sufficiently realstic to know that our increased activity — and prosperity — has not been entirely due to our professional skill or to our personalities, but to the fact that many good men were unavailable, having gone where their country needed them. These men are now coming back, and their return is the best thing that could happen to the practice of medicine here. If we who have remained have allowed ourselves to lower our standards under pressure, it is our duty to correct the fault as that pressure is removed. The profession for its own good needs the healthy stimulus that the returning veterans are beginning to provide. During the coming year it is the foremost duty and privilege of all of us, individually and collectively as an Association, to welcome back those who from patriotism took the harder road and served with our armed forces with little regard to their own comfort or safety. This welcome should not be vocal only. Whatever we can do to help them in the re-establishment of their practice, or in its initiation, as we hope that some new men, returning will choose to live and work with us, let us do with a will. We are proud of their record. If we can be of some aid to them at this time, it is our privilege. We are glad they are coming back, and we are eager to work with them for the improvement of medical practice and service in Providence.

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Providence Medical Association

REGULAR MEETING

At the Medical Library . . . 8:30 P.M.

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SURGERY IN RHODE ISLAND

JOHN E. FARRELL, A.B.

Executive Secretary, Rhode Island Medical Society and the Providence Medical Association

The following article on the question of surgery in Rhode Island first appeared in the MEDICAL NEWS of the Providence Medical Association, Vol. 2, No. 8, August, 1941. In view of the proposal for a voluntary prepaid surgical insurance program now in Rhode Island it appears pertinent to reprint this interesting discussion ..... THE EDITORS

IF there is one term in medical and hospital usage which approaches the Shakespearean dilemma of "to be or not to be" it is the expression major and minor surgery. Just where the line of demarcation lies between the two branches, if such a division is proper, no one has authoritatively determined. The Rhode Island statutes have legalized osteopathic physicians and chiropractic physicians with a restraining clause that they "shall not practice major surgery", but any inference that such wording grants rights of operative surgery in minor procedures to these physicians is a presumption that warrants consideration by the courts of the State.

It would appear that the medical concepts of what constitute major and minor surgery depend upon the individual point of view. Is an operation a major one because it is performed in a hospital? Because it is costly? Because it is possible only under a general anesthetic? Because it is a difficult step for the surgeon? Or because it places the patient's life in jeopardy?

Affirmative answers to all these questions might be justified at one time in medical progress, but hardly at present. Today more and more serious operations are being performed with the use of local anesthesia, and the hospital is used far more freely, and willingly, by the public than heretofore. Modern scientific procedures and discoveries have played their part in decreasing the risks attendant upon operations with the result that the average patient no longer views surgery as a last desperate attempt to prolong his life.

The simplest and least hazardous surgery is a major procedure to most patients, and especially to those persons of a nervous makeup. Therefore one can only make the division between so-called major and minor operations by careful consideration of the individual person, and the possible consequences of surgical procedure upon that individual.

Dr. S. S. Goldwater of New York forcefully presented this viewpoint years ago when he wrote[1] that

"A major operation is a severe or serious operation, not a slight or trivial one, but from comparatively trivial surgical procedures serious consequences sometimes result. The test lies in the gravity of the operation, which must be gauged not merely by the technical difficulty of the procedure, but by the risk to the patient; and in using the term risk I am thinking not only of the risk to life, but of the likelihood that any important bodily function may be impaired.

"Elements to be considered are: the scope of the surgical procedure; the danger of shock; the presence of known complications, which add to the risk the probability or possibility of unsuspected pre-existing surgical complications; the probability or possibility of postoperative complications; the probable duration of the operation; the age and general condition of the patient (presence of intercurrent disease, not directly related to the operation); the degree of mutilation; the amount of pain or mental anguish caused; the nature of the anesthetic used, and the risk of legal complications in the case of an unsuccessful result.

"It will not do, for example, to say that a tonsillectomy is a minor operation; it might well be this in the case of a healthy child, and especially if the operation were performed without a general anesthetic. It would scarcely be so in the case of a complete tonsillectomy performed under anesthesia on a person of advanced years (as many a sufferer will testify). But even the most hopeful form of tonsillectomy, in the most promising type of patient, can result (and occasionally does result) in lung abscess. Similarly, the removal of hemorrhoids may properly be classified as either a minor or major operation, according to the circumstances. Moreover, the very slightest surgical interference, if performed without due regard to asepsis, obviously involves a risk out of proportion to the ordinary rating of the procedure."

That the term minor surgery is in disfavor with medical authorities was pointed out in the American Medical Journal[2] by Hubert A. Royster who made

continued on page 125

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SURGERY IN RHODE ISLAND

continued from page 123

the plea that the term be eliminated because of possible implications. He advanced the arguments that "only one of 104 surgeons whom he consulted believed in the division of surgery into major or minor. The principal objection to the term, it appears, is that it is vague and ill-defined. There exist no definite criteria by which to designate any one procedure as minor or major. What appears to be a simple procedure may develop into a most complicated one. What is a minor operation in the hands of a skillful surgeon may prove a major one in the hands of the unskilled surgeon. Such criteria as time required to perform an operation, the mortality, the skill required, the question of anesthesia, the question of whether it can be performed in the office or requires hospitalization are all variables. The suggested substitutes for the term minor surgery, such as office surgery, ambulant or dispensary surgery, are hardly an improvement, (for) all surgery is based on the same fundamental principles and is therefore not divisible. In no other field of medicine does a similar division into major and minor procedures exist. Actually the term minor surgery has largely disappeared from the curriculums of our leading medical schools."

One of the few attempts made by legislative groups to answer this puzzling question is that of the Board of Regents of the University of the State of New York (State Education Department) which attempted to clarify the 1939 amendment to the New York osteopathic law whereby osteopaths are permitted to "use instruments for minor surgical procedures" if they can satisfy the Board of Regents that they have had sufficient instruction and training. The definition arrived at by the Board stipulates that "The phrase minor surgical procedures, as used in the law, shall be construed to include all surgical procedures, excepting those involved in incision for: the opening of a natural body cavity, the removal of benign or malignant tumors, bone fractures, the amputation of extremity or an appendage, the removal of any gland or organ or part thereof, or plastic surgery of the human body."

In view of this very apparent lack of understanding and legal interpretation of what constitutes major and minor surgery for the medical man it is difficult for one to realize upon what grounds the Legislatures in 1927 and 1931 saw fit to adopt the amendments to the statutes relating to the practice of osteopathy and of chiropractic to provide that neither group of healers "shall practice major surgery."

It is a fundamental principle of statutory construction that the Legislature must be presumed to have had in mind all previous legislation upon the subject, and the application of this principle regarding these amendments offers the only conclusion that the Legislature was merely taking cognizance of the fact that manipulative surgery was encompassed in the theories of practice of these healers. Certainly the Legislatures of 1927 and 1931 must have known of the initial statutes licensing osteopathy and chiropractic in this State, in both of which opposition to any surgical procedures other than such as might be performed by manual manipulation are expressed. That any invasion of the field of operative surgery was intended is indeed a rash presumption.

When osteopathy was recognized by legislative enactment in Rhode Island in 1914 the practice was clearly defined,[3] and the definition still prevails, that it is "to be the treatment by manipulation of diseased or abnormal conditions of the human body." And the first chiropractic legislation in this State,[4] passed in 1927, defined chiropractic as "the science of palpating and adjusting the articulations of the human spinal column by hand, for the elimination of the cause of disease, corrective and orthopedic gymnastics, and dietetics."

Subsequent legislative acts have been construed by healers in these groups to have granted them operative surgical privileges, but such presumption will hardly stand the test of challenge. The amendment to the osteopathic law[5] passed in 1927 provided that an osteopath who can satisfy the division of examiners that he has completed a year of post graduate internship in a hospital approved by the division may be granted a license "to practice any branch of surgery." This reference to "any branch of surgery", poses another question. Are we not to presume that the Legislature meant any branch of *manipulative* surgery in view of the teaching and theory of the practise of osteopathy? Or are we to presume, as the osteopaths would have us do, that this wording removes the restriction relative to major surgery, and that the all inclusive "any" allows them to enter the field of operative surgery to which they are opposed in theory?

Our contention that any invasion of the field of operative surgery is an invasion of the field of medicine is borne out in the opinion handed down by the Supreme Court of the State of Nebraska[6] last May (1941) when it ruled that osteopaths may not practise operative surgery. This Court stated in part that

"The word 'surgery' used in its general sense in connection with the profession of osteopathy means surgery by manual manipulation and was never meant to include operative surgery as we now understand it. The correctness of this statement is evidenced by the very principles of osteopathy to the effect that the general use of a knife or other instruments in surgical operations was regarded

continued on page 127



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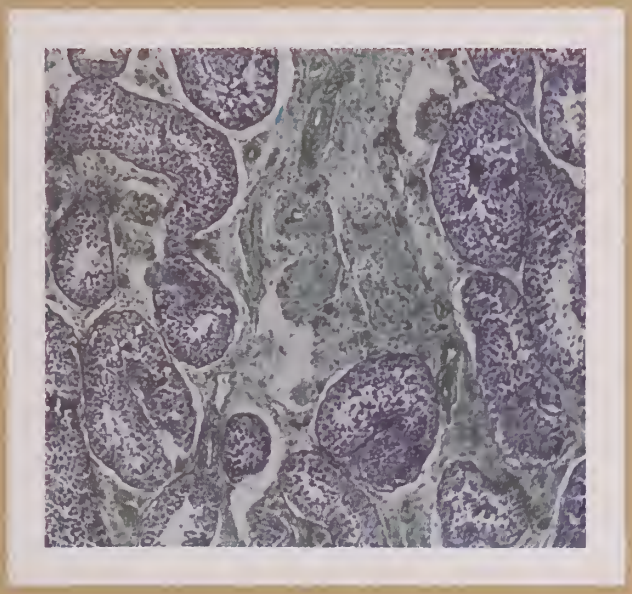
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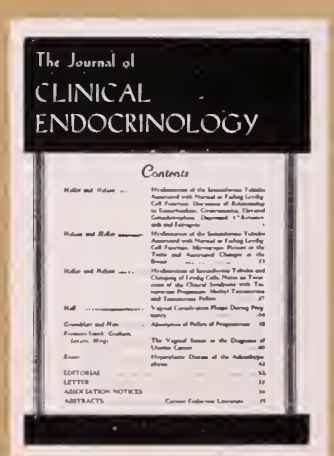
Journal of the American Medical Association, 127:705, 1945.



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Pennsylvania Medical Journal, 48:780, 1945.



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Journal of Clinical Endocrinology, 2:237, 1942.

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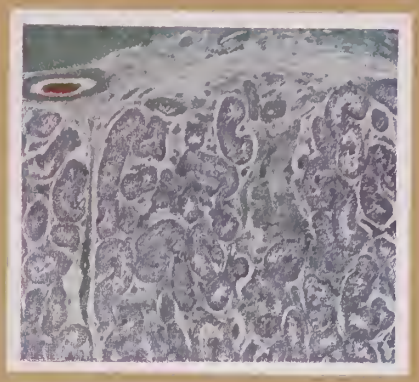
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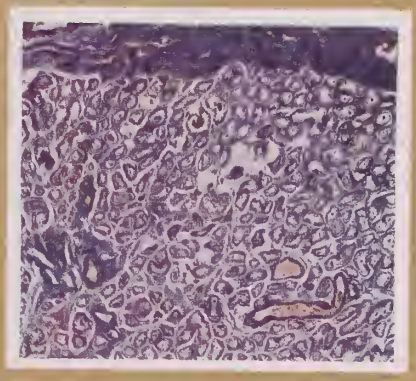
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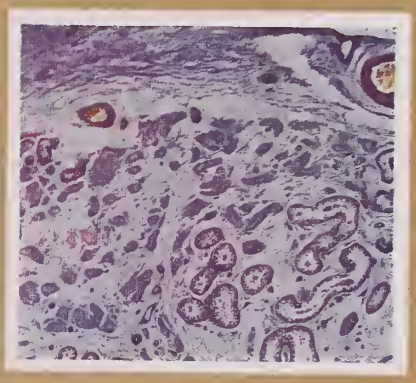
HUMAN TESTIS: Transectian af the tubules. Narmal male, 30 years af age.

2



HUMAN TESTIS: Transectian af the tubules. Maderate atraphy. Male, 59 years of age.

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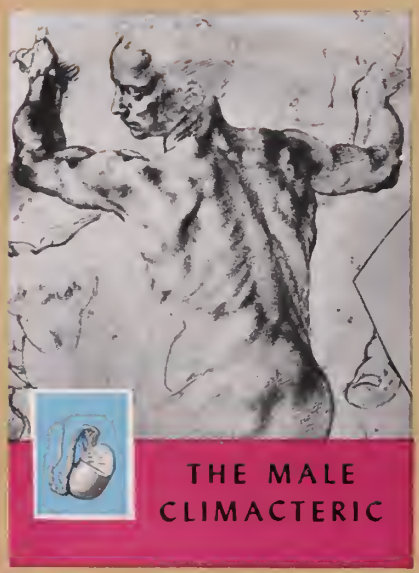


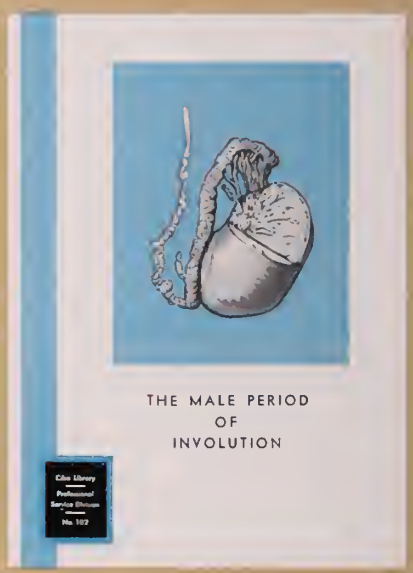
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SURGERY IN RHODE ISLAND

continued from page 125

as unnecessary and opposed to the osteopathic system of treatment. The practice of osteopathy and operative surgery has long been recognized as two separate and distinct things. Separate boards have been set up in this state for the examination of those applying for licenses to practice medicine and surgery and those desiring to practice osteopathy. It is urged that the principles of osteopathy have changed and that experience and learning have produced certain advances that must be recognized. If osteopathy has changed merely by a self-serving attempt to broaden its scope by invading fields requiring a different license, we can only say that the legislature has never recognized any such additions to the profession. If the changes are the result of advancements in the profession, of course, they still constitute the practice of osteopathy. But the practice of operative surgery by an osteopath is an invasion of the field of the physician and surgeon as it is geneally known and is not an evolutionary advancement of the profession of osteopathy. State v. Gleason, 118 Kan. 1, 79 Pac. (2d) 911; Burke v. Kansas State Osteopathic Assn. 111 Fed. (2d) 250."

This conclusive court opinion might well be applied to a study of our statutes, for osteopathy and chiropractic stem from basic sources, and the practises are fundamentally the same in Rhode Island as in other states. The mere fact that branches of medicine and surgery may be taught to increase the knowledge of the student in the anatomy and functions of the various parts of the human body, for the purpose of better fitting him to practise osteopathy or chiropractic, does not warrant him to invade either medicine or surgery on the theory that they constitute his practise. The scope of osteopathy and chiropractic are well known, and schools and colleges teaching these theories must stay within their boundaries.

The law may be poorly phrased, but the main fault lies in the unrestricted freedom in the interpretation of it by those whom it would govern and restrain. The Rhode Island Supreme Court might well consider the particular phraseology to determine the intent of the Legislature, and at the same time to dispel all doubt as to what constitutes the field of surgery.

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[1] Modern Hospital, Vol. XXVII, No. 3, September, 1926.

[2] Journal of A.M.A., Vol. III, No. 7, August 13, 1938.

[3] Chapter 1058, Acts and Resolves, Rhode Island General Assembly, January Session, 1914.

[4] Chapter 1067, Public Laws, Rhode Island, January Sessions 1927.

[5] Chapter 1068, Public Laws, Rhode Island, January Session, 1927.

[6] State of Nebraska v. Gable, No. 30980, Filed May 2, 1941.

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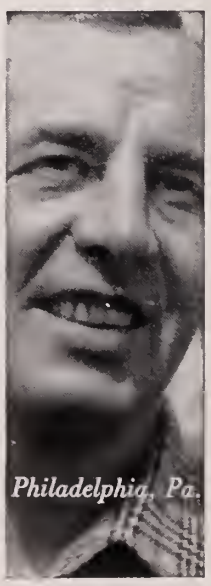
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SUPPLIED as ¼% and 1% in isotonic salt solution, and as ¼% in isotonic solution of three chlorides (Ringer's), bottles of 1 fl. oz.; ½% jelly in ⅜ oz. collapsible tubes with applicator.

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COMMUNITY NEEDS AND THE HOSPITAL FUTURE

OLIVER G. PRATT, *Executive Director, Rhode Island Hospital*

THE people of Rhode Island may anticipate a comprehensive and most modern hospital system designed to meet every health need.

The medical profession and the philanthropists have set a pattern for leadership in health service for all the people of this State. In recent years the Blue Cross organization has been introduced to aid in removing the financial burden by providing a means for budgeting for hospital care. The success of this movement is attested to by the fact that the Rhode Island Hospital Service Plan leads the nation in the percentage of people served, having enrolled fifty percent of the population.

Great advances have been made in the science of medicine. The challenge for tomorrow is to correlate preventive and curative medicine more completely, and to develop a hospital system that will assist in making this combined scientific and life-saving service readily available to all.

Today we find specialists grouped in urban centers partly because of the need for working with their colleagues in other specialties, but also because there is adequate clinical material. The ratio of population to certain medical specialists has been rather definitely defined. Experience indicates that the Radiologist can serve from 50,000 to 75,000 people, and the Pathologist can serve up to 100,000 people. With our present lack of a hospital system this medico-economic factor plays a real part in limiting the availability of modern medical practice.

This example alone indicates the wisdom of developing a hospital system that will redound jointly to the benefit of the physician and the patient. Many other reasons for correlation of the work of hospitals which would be in the interest of the physician and patient alike are obvious to the members of the profession.

Rhode Island lends itself very readily to a statewide voluntary demonstration of cooperative effort for distribution of medical service to all its people. The concentration of population, its size, the location, leadership and quality of existing hospitals, the acceptance of Blue Cross, the leadership of the Medical Society in developing a voluntary prepayment medical-surgical insurance plan, the interest in and appreciation of the value and frank necessity of continuing medical education, the presence of universities together with the interest of their officials and faculties, and the willingness of business leaders and individuals to contribute generously, are each important factors. When correlated they will provide the basis with which to create a system of hospitals capable of meeting every health need of all the people of Rhode Island, and which may well set a pattern for the country.

The benefits which will accrue may be detailed briefly as follows:

1. The mechanics will provide for a program of continuing and comprenhensive medical education for all physicians including supervised resident training in the smaller hospitals. (An adaptation of this plan is today aiding in providing educational opportunities for physicians returning from service with the armed forces).
2. All medical services will be available to all patients in all hospitals by a mutually agreeable consultation service.
3. Smaller hospitals and health centers with the assistance of necessary specialists can provide the mechanics for taking preventive medicine and diagnostic service to the people. The average citizen will travel a long distance to secure medical attention only for an acute illness.
4. Planning and correlation will avoid duplication of capital outlay, and equally important it will provide more economical service for most patients.

continued on page 133

Formulac

the new vitamin-fortified infant food

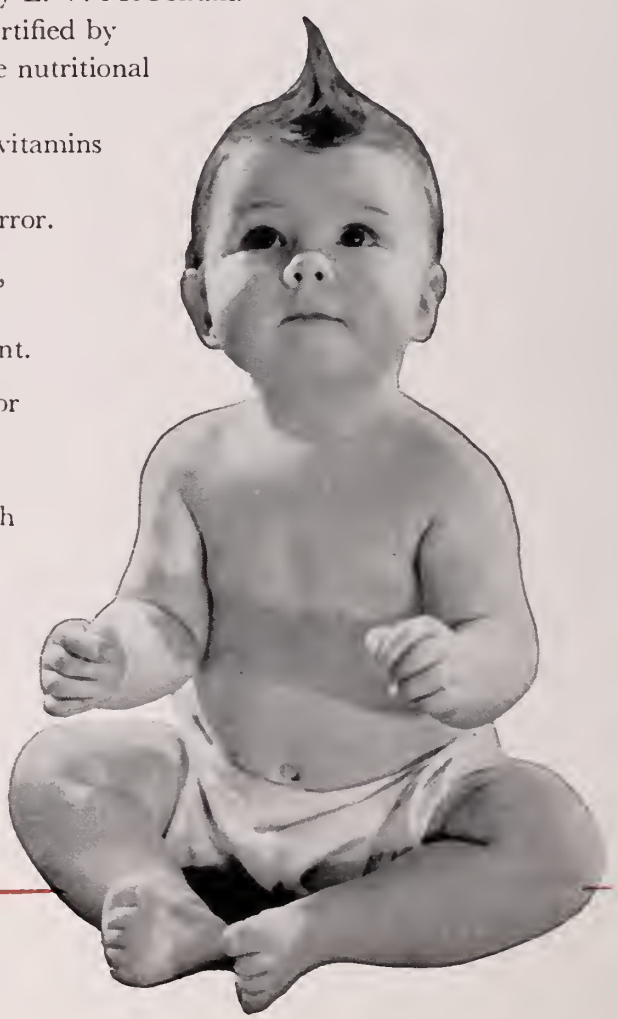
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COMMUNITY NEEDS AND THE HOSPITAL FUTURE

continued from page 131

5. There will be an improved quality of service in all hospitals. The smaller hospital will benefit by the availability of specialists and laboratory and X-ray service from the larger hospitals. The larger hospital will be able to do more for its patients because it will receive only the very complicated cases, carefully screened at the local hospital.
6. There will be greater opportunities for research and for standardization of certain elements of hospital management.

The hospital field has developed rapidly in the last decade, but there have been many limiting adjustments during the last five years. We are not going back to the pre-war pattern. We are going forward to a new type that will better serve all the people. We will need all our wisdom, maturity and foresight to gain our objective.

Physicians, hospitals and the people they serve must agree on certain policies to insure success.

1. The accepted patient-physician relationship must continue.
2. There must be an inherent desire to care for the patient in his home hospital and to move him to a hospital in a larger center only when it is in the interest of the patient.
3. Every effort must be made to develop the outlying hospitals.
4. The voluntary coordination of the work of hospitals must be on a firm foundation. The development must be from the "grass roots" up rather than from the top down.

The American people are profiting by the best medical care and hospital service available in the world. From what started as merely custodial care we find the voluntary hospital becoming a medical and health center, an institution devoted to education and research as well as to the diagnosis, care and cure of the sick.

The individual voluntary hospitals are doing remarkable work today. The future development will be to weld the individual hospitals into a system of hospitals. Tomorrow we can anticipate that a voluntary system of voluntary hospitals will make available to all the people a type of hospital service which will parallel in scope and quality the ever increasing scientific and complicated health and life-saving service of the medical profession.

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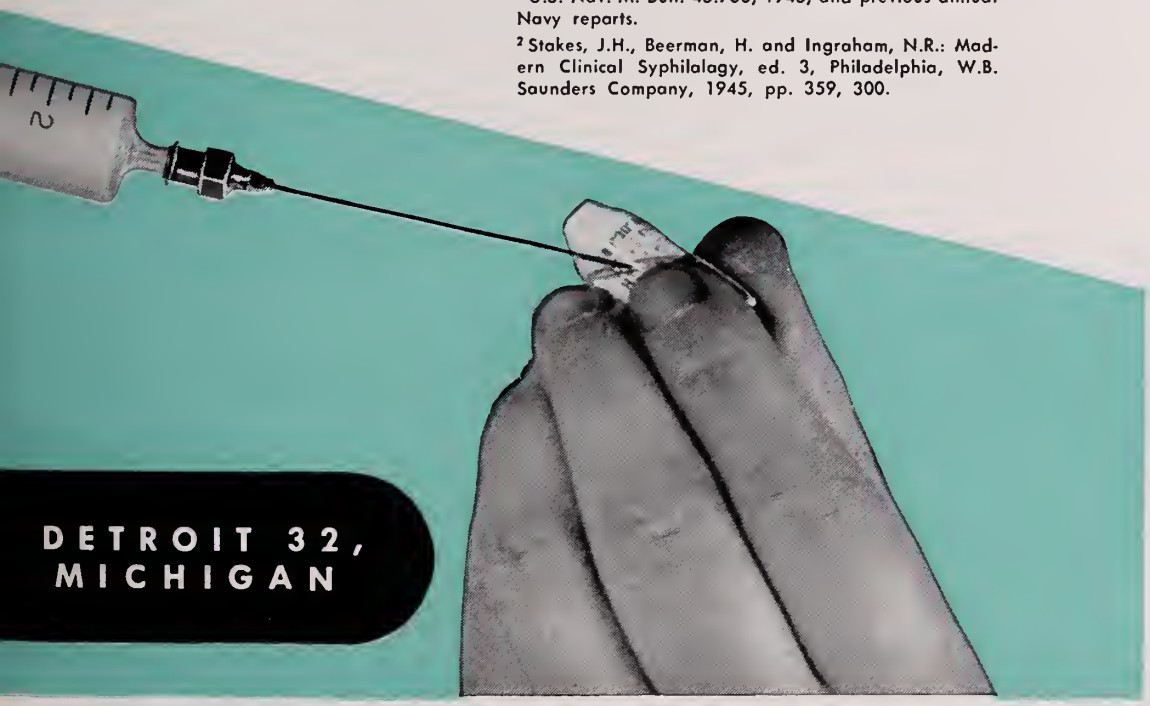
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[1] U.S. Nav. M. Bull. 45:783, 1945, and previous annual Navy reparts.

[2] Stokes, J.H., Beerman, H. and Ingraham, N.R.: Modern Clinical Syphilalagy, ed. 3, Philadelphia, W.B. Saunders Company, 1945, pp. 359, 300.



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More Doctors Smoke Camels

than any other cigarette



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WELCOME HOME!

The Rhode Island Medical Society reports the following Rhode Island physicians as honorably released from active duty, most of whom have resumed the private practice of medicine in this State as of February 1, 1946. Additional listings will be made each month and members are urged to report promptly upon their return to Rhode Island.

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E. J. Bernasconi, M.D., 726 Broad Street, Providence
Morris Botvin, M.D., 155 Angell Street, Providence
Reginald Boucher, M.D., 704 Main Street, Pawtucket
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Francis H. Chafee, M.D., 454 Angell Street, Providence
William P. Davis, M.D., 182 Waterman Street, Providence
John A. Dillon, M.D., 255 Hope Street, Providence
Thomas A. Egan, M.D., 986 Smith Street, Providence
Richard Femino, M.D., 666 Douglas Avenue, Providence
Duncan H. C. Ferguson, Jr., M.D., 75 Park Place, Pawtucket
Stanley Freedman, M.D., 126 Waterman Street, Providence
Albert J. Gaudet, M.D., 592 Smithfield Avenue, Pawtucket
Seebert J. Goldowsky, M.D., 209 Angell Street, Providence
John T. Keohane, M.D., 568 Broad Street, Providence
David Litchman, M.D., 102 Waterman Street, Providence
Llewellyn J. McGovern, M.D., 162 Indiana Avenue, Providence
Nicholas A. Pournaras, M.D., 327 Elmwood Avenue, Providence
William J. Schwab, M.D., 616 Hope Street, Providence
Raymond E. Stevens, M.D., 398 Greenwood Avenue, Rumford
Ernest D. Thompson, M.D., 218-220 Hall Building, Pawtucket
Jacob P. Warren, M.D., 541 Hope Street, Providence
Frederick A. Webster, M.D., 70 Greenwood Avenue, Rumford
Robert J. Williams, M.D., Rhode Island Hospital

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Capt. William A. Stoops, MC, USNR, U. S. Naval Hospital, Newport, Rhode Island
Capt. William A. Reid, MC, Thomas M. England General Hospital, Atlantic City, N. J.
Lt. William F. Maher, MC, M.F.S.S., Carlisle Barracks, Pennsylvania
Lt. Comdr. Frederic W. Ripley, Jr., MC, USNR, U. S. Naval Hospital, Newport, Rhode Island
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Lt. Comdr. Banice Feinberg, US Naval Hospital, Jacksonville, Florida
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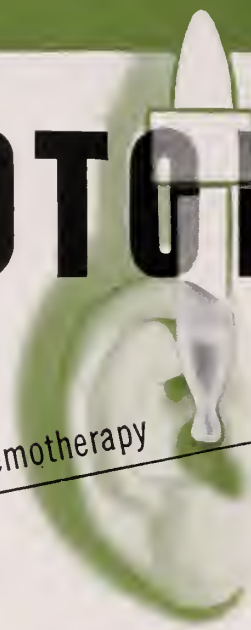


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1. Tsuchiya, H. M. et al: Proc. Soc. Exp. Biol. and Med., *50*:262, 1942.
2. McClintock, L. A. and Goodale, R. H.: U. S. Naval Med. Bull., *41*:1057, 1943.
3. Strakosch, E. A. and Clark, W. G.: Minn. Med., *26*:276, 1943. Brown, C. et al: Am. J. Surg., to be published.

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THE OBLIGATIONS OF AN INTERNIST TO A GENERAL SURGEON*

THOMAS FINDLEY, M.D.

The Author. *Thomas Findley, M.D., of New Orleans, La. Assistant Professor of Clinical Medicine, School of Medicine, Tulane University and Director of Section on Internal Medicine, Ochsner Clinic.*

An internist has been defined as a man who is totally unable to answer either yes or no to any question. The definition was made in jest but there is much truth to it. If there is such a thing as a typical internist, he is a sedentary individual, curious, skeptical, reflective. He is accustomed to look at the patient as a unit rather than as a collection of separate organs and, if he has had the fundamental scientific training he should have had, he is eager to distinguish between a fact and someone's opinion. Although often powerless to suggest an alternative procedure, he regards every operation as an exercise in violent therapeutics and a confession of failure to cure. He is, however, humble before the complexities of modern surgical technique. His fees are not such as to command general admiration.

The surgeon, on the other hand, is a man of action. He lives in an exhilarating world of knives, blood, and groans. His tempo is of necessity rapid. He is inclined to look at his less kinetic colleague with an air of puzzled condescension but may, in a relaxed moment, admit that the medical man is occasionally able to assist uncomfortable dowagers in the selection of a cathartic. Accustomed to legerdemain and quick results, he is apt to regard the diagnosis and treatment of a headache, for example, as a trivial matter, forgetting that the internist may require hours of probing before discovering that what the patient needs is not a new pair of glasses but a different mother-in-law. The surgeon and the internist are workers in the same vineyard, but their points of view are inevitably different.

Of those patients who come to any clinic for help there is a certain small percentage who present definite and well-demarcated problems—a broken arm, a decompensated heart, a gravid uterus, for example. Of these the internist will claim his share and do what he can. Over and above these, however, is a larger number with ill-defined complaints who tax the resources of the entire staff. These are the ones who are commonly x-rayed from head to toe, whose fluids and excrements are examined with great skill, into whose every orifice electric lights are inserted—to no avail! The standard reaction on the part of the medical attendant then is that of anger. The patient is automatically regarded as an imposter who has no right to his symptoms and his visit to the clinic is looked upon as a nuisance and an intrusion. Actually, of course, these are perhaps the sickest people we see. It may be argued that they are merely suffering from such elemental emotions as grief, frustration, inadequacy, fear, or sorrow, that their problems are therefore non-medical, and that the clinic is not required to help them. If this is so, we are amateur physicians indeed.

W. R. Houston has frequently and eloquently pointed out that sickness of any sort carries with it a curious and sometimes irresistible demand for action. There is nothing to which a sick man will not submit himself—he is gladly purged, puked, bled, transfused, sweated, infused, cut, frozen, heated, and shocked and he will swallow literally anything. It is seldom that the consequences of these actions are considered, for it is action itself that is demanded. Even the most normal of us howl and gyrate when thrust suddenly into pain; these actions serve no useful purpose whatever, but somehow they seem to bring relief.

And so these people come to us in their distress demanding both action and relief. This demand comes not only from the patient but from the family as well. One can never enter a sickroom without being immediately aware of immense forces at work. The urge to violence is often so compelling that it requires great courage to follow the wiser course and do nothing. Certainly it is a commonplace experience for patients to complain that we have found nothing for which to operate upon them, and it is no consolation to these people to be told that their roentgenograms and blood tests are negative. It is another curious fact that no one minds being told that he has something wrong with one or more of his organs, but he bitterly resents the implication that the trouble lies within himself. A heart that is failing a little, a sluggish liver, a pair of weak lungs—these are cherished and respected ailments—but a personality defect is accepted with the greatest reluctance.

continued on page 141

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OBLIGATIONS OF INTERNIST TO A GENERAL SURGEON

concluded from page 139

In dealing, as it must, with individuals whose primary difficulty is emotional, a clinic finds itself in a peculiarly dangerous situation because a certain percentage of these patients will inevitably present some physical abnormality which, in a more stable host, would be a legitimate surgical target. The diagnosis of anxiety state, chronic reactive depression, or conversion hysteria is not made by exclusion, however, and it would be a major error to assume that an elderly housewife could not have a psychogenic backache and a fibroid tumor as well. The surgeon often accuses the internist of complacency and ignorance when he chooses to ignore a uterus which is not quite perpendicular, or a solitary gallstone, or a pair of tonsils from which a fluid of unknown composition can be expressed. There are certain people, however, who demand violence; the surgeon enjoys removing organs and one function of the internist is to see that these two never meet.

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MEDICAL OPINION IN RHODE ISLAND

Report 3. Prepaid Hospital Insurance

Prepared by the
Committee on Postgraduate Education

Alex M. Burgess, M.D., B. Earl Clarke, M.D., Harmon P. B. Jordan, M.D., Elihu S. Wing, M.D., and John F. Kenney, M.D.

This is the third of the summaries of medical opinion based on answers to the questionnaire sent to all members of the Rhode Island Medical Society in April 1945. The previous article dealth with Diagnostic Centers and Group Practice. This communication is concerned with the answers to question No. 18 which reads as follows:—

What is your opinion of:

(a) The Blue Cross Plan for hospitalization?

(b) Compulsory hospital insurance for employed workers?

(c) Expanding the use of existing voluntary hospital insurance organizations?

As in the case of many of the other questions several replies were received in which question 18 was either wholly or partly unanswered but nevertheless there were only nine in which part (a) concerning the Blue Cross Plan was ignored. The results are as follows:

In favor of the Blue Cross Plan—159
Opposed—9

Of the 159 who expressed themselves in favor of the plan 80 were evidently enthusiastic and used such expressions as "excellent" or "ideal" or the like to indicate more than mere approval. Of those who opposed the plan two stated that it was "oversold" and six that they believed that no more memberships should be sold until more hospital beds are available. The lack of hospital facilities is shown by the statement of one physician that the plan "cannot deliver the goods". Other unfavorable comments are of interest. Several show a feeling that the benefits should be increased in one or more particulars, "Should cover X-ray, operating room, etc.", "Not adequate, should provide longer periods of hospitalization", "X-rays should be included", "Should be expanded to include a reasonable fee for the attending physician." The possibility of abuse of the service is suggested by these statements: "Fills up hospital beds with those who don't need hospital beds" and "a few patients try to be hospitalized to recover minor benefits." One other interesting comment was made in regard to the plan, a physician stating that it is "fraught with danger to a self governed medical society since it can completely dominate all participating hospitals many of which are governed by lay persons." Despite all the above criticisms, some of which indicate problems and difficulties with which the Blue Cross has to contend, it is evident that the local profession is enthusiastically in favor of the plan.

A tabulation of the answers to part (b) which deals with compulsory hospital insurance gave a somewhat unexpected result. It is generally supposed that the medical profession is very strongly opposed to compulsory insurance and yet of the 125 answers to this question, 50 were in favor of this form of insurance while 75 opposed it, a proportion of only 3 to 2 in opposition. Favorable comments included the opinion that it is "bound to come" and "possibilities good if kept out of political control and out of the general treasury of the state." Six physicians indicated enthusiasm by the word "excellent" or the like. Several of the majority group who opposed compulsory insurance were also emphatic. The commonest objection was that compulsory insurance constituted an "infringement on the rights of an individual", was "undemocratic" or "socialistic."

The answers to part (c) indicated a strong opinion that the use of existing voluntary hospital insurance organizations should be expanded. Of the 122 replies to this question 114 were in favor of this expansion and only 8 opposed. 8 of those in favor of such expansion indicated enthusiasm in their comments. No unfavorable comments of interest were noted.

In summary, then, we may say that the local medical profession, as represented by the group who answered the questionnaire, has expressed very strong approval of the Blue Cross Plan and are of the opinion that existing voluntary hospital insurance organizations in general should be expanded. In regard to compulsory hospital insurance for employed workers the profession, as judged by this group, is opposed, but by the rather narrow margin of 3 to 2.

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*N. Y. State Journ. Med. 35 No. 11,590
Laryngoscope 1935, XLV, No. 2. 149-154

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1. Lehr, D.: Proc. Soc. Exper. Biol. & Med. *58*:11, 1945.
2. Lehr, D.: In press.

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DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

The Ninety-ninth Annual Meeting of the Providence Medical Association was held at the Medical Library on Monday, January 7, 1946. The meeting was called to order by President B. Earl Clarke at 8:30 p. m.

The Secretary read the records of the previous meeting of the Association which were accepted and placed on record. The Secretary presented the Annual Report for the year 1945 which was accepted and placed on record.

Dr. Herbert E. Harris, Treasurer, submitted his Annual Report for the year 1945 which was accepted and placed on record.

The President introduced Dr. Charles L. Farrell of Pawtucket, a member of the Board of Directors of the American Association of Physicians and Surgeons, who briefly outlined the objectives and programs of that association.

The Secretary reported for the Executive Committee as follows:

That it had received a proposed budget prepared by the Treasurer for the operation of the Association in 1946, calling for a total expenditure of $6,842.

That the Executive Committee recommends the annual dues for each active member in 1946, exclusive of members in service with the armed forces, be $15, and for associate members, $5.

Dr. Harry C. Messinger moved the acceptance of the report of the Executive Committee and the approval of the recommendations submitted to the Association. The motion was seconded and adopted.

Dr. B. Earl Clarke delivered his presidential address, in which he reviewed the work of the Association for the past year. He stressed the necessity of continuing the Smoke Abatement Committee as a permanent committee which should be sure to see that interest does not lag in the long-term program necessary to accomplish results. Dr. Clarke advised that our members of the House of Delegates of the Rhode Island Medical Society should organize and should report back to the Association regularly.

Dr. Clarke presented a most scholarly and profound exposition of the present trend in the matter of Social Security. For various reasons the practice of medicine and practitioners of medicine have been thrown into the center of the current in this stream of change. Like a swimmer in trouble, the medical profession has grasped at something or anything for help in the situation. This "something" is voluntary prepaid medical care. Dr. Clarke does not consider its development as a satisfactory or complete answer to the situation.

Dr. Clarke made a plea for individual initiative and for the placing of spiritual values above material ones as being the only satisfactory answer to many present-day problems. Our retiring President's able speech is worthy of widespread re-publication.

The President called for nominations for the President of the Association for 1946. The Secretary reported that the Executive Committee had recommended the nomination of Dr. Paul C. Cook, and he stated that there had been no counter nominations. It was moved that Dr. Cook be elected President of the Association. The motion was seconded and unanimously adopted. Dr. Clarke appointed Drs. Jesse P. Eddy, III and Edward S. Cameron as a committee to escort the new President to the rostrum.

Dr. Cook expressed his appreciation to the membership for the honor bestowed on him, and he briefly outlined some of the problems which he felt warranted the attention of the Association in the coming months.

Dr. Cook stressed the need for improvement in the matter of pollution of the waters of the Narragansett Bay and the rivers of Rhode Island. He appointed a committee to report on this matter after investigation. Dr. Cook spoke at considerable length concerning the problems of returning veterans and extended to them a warm welcome. Their help is greatly needed in providing adequate medical care of high standard.

Dr. Cook called for nominations for the office of Vice President. The Secretary read the slate of officers recommended by the Executive Committee and stated that there had been no counter nominations. Dr. Clifton B. Leech moved that the entire slate as recommended by the Executive Committee be adopted. Dr. Jackvony seconded the nomination, and it was unanimously passed. The Secretary was authorized to cast a vote to elect the entire slate

continued on page 149

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 147

of officers to serve the Association in 1946, as follows:

President	PAUL C. COOK, M.D.
Vice President	GUY W. WELLS, M.D.
Secretary	FRANK B. CUTTS, M.D.
Treasurer	WILLIAM P. DAVIS, M.D.
Executive Committee	B. EARL CLARKE, M.D. FRANK W. DIMMITT, M.D.

(2 members for 5 year terms)

Trustee of R. I. Medical Library,
HERBERT E. HARRIS, M.D.

Delegates to House of Delegates of R. I. Medical Society:

B. H. Buxton, M.D.
H. G. Calder, M.D.
A. V. MIGLIACCIO, M.D.
A. H. Fox, M.D.
A. Giura, M.D.
A. M. Burgess, M.D.
E. M. Porter, M.D.
H. E. Utter, M.D.
G. W. Davis, M.D.
K. K. Gregory, M.D.
E. V. Famiglietti, M.D.
P. F. Harrington, M.D.
F. I. Matteo, M.D.
E. W. Bishop, M.D.
G. E. Crane, M.D.
A. E. Martin, M.D.
A. H. Jackvony, M.D.
B. E. Clarke, M.D.
P. C. Cook, M.D.
P. P. Chase, M.D.
J. L. Belliotti, M.D.
R. H. Whitmarsh, M.D.
F. Cutts, M.D.
W. P. Davis, M.D.
W. Horan, M.D.
P. I. O'Rourke, M.D.
R. Baldridge, M.D.
G. Waterman, M.D.
H. A. Lawson, M.D.

The President stated that the reports of the various standing Committees of the Association had been submitted to the Secretary, and these reports would be published in the *Rhode Island Medical Journal*. He invited any chairman of any committee to supplement his remarks at this time if he desired to do so.

Dr. Harry C. Messinger, Chairman of the Committee on Ethics and Deportment, briefly reviewed the background of the cases brought before his Committee, and he urged the members of the Association to keep very accurate records regarding the treatment of each patient at the time of treatment, and thereby guarantee additional protection in the event of threatened action for mal practice.

The Secretary reported that the Executive Committee recommended the election to active membership in the Association Dr. William Andrew McDonnell, and Dr. Francis William Nevitt. Dr. Henry Utter moved the unanimous election of these applicants to membership in the Association. The motion was seconded and adopted.

Dr. Cook announced that he was appointing a committee to consist of Dr. Charles McDonald and Dr. Samuel Clark to prepare the Association's tribute to the late Dr. Milton Korb.

Dr. Cook announced that the February meeting of the Association would be a joint meeting with the Rhode Island Medical Society, and he stated that it was hoped that Major General Paul R. Hawley, Acting Surgeon General of the United States Veterans Administration, would be present, together with Dr. Herman C. Pitts, President-elect of the Society and Chairman of the Surgical Insurance Study Committee, to address the membership.

Dr. Cook invited Dr. B. Earl Clarke to return to the rostrum to present Dr. Benjamin Castleman, acting Pathologist, Massachusetts General Hospital. Dr. Castleman spoke on the subject, "Pulmonary Embolism and Infarction."

Dr. Castleman spoke of the discrepancies which in the past have been common between antemortem X-ray findings and postmortem observations. He told of a satisfactory technique for taking chest films of cadavers and mentioned a technique of inflating the lungs so as to make them more lifelike.

He stressed the fact that infarcts are not typically triangular in shape. They are of this shape at the costophrenic angle, but the apex of the triangle is at the margin, the base of the triangle being located proximally. This proximal, somewhat rounded aspect of an infarct is referred to as "Hampton's Hump," and may be seen roentgenologically.

Dr. Castleman stated that many white lines often considered healed tuberculosis or pseudo-septa are

continued on page 151

YEARS OF SERVICE

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 149

in reality healed infarcts. Probably the source of emboli causing infarction is the deep veins of the legs in more than 95 per cent of cases. In combating the situation, it is possible to tie even the inferior vena cava.

Dr. Castleman's clear and thorough exposition of his subject was very instructive. The meeting adjourned at 10:20 p. m. Attendance: 97. Collation was served.

Respectfully submitted,

FRANK W. DIMMITT, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The January meeting of the Kent County Medical Society was held on January 10, 1946, at the Toll Gate in Westcott.

Minutes of the December meeting were read and accepted.

The Hospital Investigation Committee reported as follows:

Dr. George Young, Chairman, stated that this Committee met on December 26 and decided to invite twelve representative lay members of Kent County as advisors to the next meeting scheduled for January 23. More complete details will be forthcoming at that time.

Dr. Guy Wells, guest speaker, then presented excellent and very interesting color projections of films taken during his stay with the 5th Army as Colonel in Africa, French Morocco, Italy, Naples, Avelina, Sorrento, Cap Gris, Mount Vesuvius, Pompeii, Rome, etc. Dr. Wells emphasized the point that much illness prevailing among army personnel would have been avoided had the country, the terrain, and its climate been known and well understood beforehand.

Dr. Cogswell, also an Army Colonel, accompanying Dr. Wells, spoke of his recent experiences while in Japan, where now epidemics of tuberculosis, diphtheria, amebic dysentery, etc., are rife. He stressed the point that tropical medicine is no longer confined to the tropics but will be part of our medical practice now that our men are returning from these countries where malaria and filariasis were endemic.

The meeting adjourned. Dinner was served.

There were fifteen members present and two guests.

Respectfully submitted,

J. E. VIDAL, M.D., *Secretary*

Postural Symptoms During Pregnancy Often Averted Or Relieved By A SPENCER SUPPORT



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A Spencer antepartum support designed especially for this woman. Equally effective for postpartum period.

Abdominal support provides a rest for the weight of the abdomen and is accurately correlated with support to back, thus effecting marked posture improvement.

Light, flexible, easily adjusted to increasing development.

Note, also, the Spencer antepartum-postpartum breast support designed especially for her.

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Vitamin B_6 (Pyridoxine Hydrochloride).....0.3 mg.
Niacinamide.....15 mg.
Calcium Pantothenate.....1 mg.
*Mixed Natural Tocopherols.....3.4 mg.

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"Rheumatoid arthritis is a systemic disease; the patient must be treated as a whole, rather than have local treatment to his joints alone."*

THIS statement by the American Rheumatism Association Committee is the keynote of the present successful method of treating arthritic patients. To produce the best results anti-arthritic therapy must combat not only the joint changes, but also the systemic disturbances so frequently encountered in chronic arthritis. This systemic approach requires a multiphasic therapeutic regimen which must include correction of disturbed physiologic functions, optimal nutrition, elimination of foci of infection, mental and physical rest, supervised exercise, physical therapy, and orthopedic measures.

Because of its rational composition, Darthronol merits inclusion in every anti-arthritic program. The combined pharmacodynamic and nutritional influence of its nine active ingredients makes it an efficacious therapeutic measure whenever the chronic arthritides must be combated.

*The Primer on Arthritis prepared by a Committee of The American Rheumatism Association and published in The Journal of The American Medical Association, volume 119, page 1089, August 1, 1942.

Complete bibliography on request

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Built on a *firm foundation,* the Leaning Tower of Pisa has withstood the centuries . . . so, too, health and vigor in infancy and the years ahead depend on a *firm foundation* of optimum nutrition. • BIOLAC, when supplemented with vitamin C, is a valuable infant food whose ample milk proteins constitute an adequate source of all essential amino acids . . . the indispensable *foundation stones* for sound tissues. • BIOLAC closely approximates mother's milk in safety, simplicity, and nutritional value.

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Quickly prepared . . . easily calculated: 1 fl. oz. Biolac to 1½ fl. oz. water per lb. of body weight.



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Too often it's on with the bib, on with the battle! The fruitless struggle between mother and baby goes on at every feeding. Mealtime can again be "peace time" when 'Dexin' brand High Dextrin Carbohydrate helps form good feeding habits without the commando tactics that leave both mother and baby exhausted, upset.

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Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available Carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.
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ANNUAL REPORTS
of the
PROVIDENCE MEDICAL ASSOCIATION
1945

ANNUAL REPORT OF THE SECRETARY

Providence Medical Association, January 7, 1946

During the year 1945 the Providence Medical Association held eight regular meetings, two of which were joint meetings, one with the Rhode Island Medical Society in February, and one with the Rhode Island State Dental Society in November. Seven members of the Association and eleven out-of-state speakers contributed to the scientific programs at these meetings. The average attendance at the meetings was 90 members.

The topics and the speakers presenting them during the year were as follows:

"Management of Vaginal Bleeding," by Dr. Mario A. Castallo of Philadelphia.
"Practical Aspects of the Treatment of Shock," by Dr. Charles Janeway of Boston.
"Lessons Learned from the Treatment of Burns from the Hartford Circus Disaster," by Drs. Donald B. Wells, John C. Leonard, Ralph E. Kendall, and Maurice T. Root of Hartford.
"Coarctation of the Aorta," by Dr. Frank T. Fulton.
"Pancreatic Insufficiency and the Coeliac Syndrome," by Dr. Sidney Farber, of Boston.
"The Medical Aspects of Air Pollution," by Dr. Clarence A. Mills of Cincinnati.
"Hugh Owen Thomas: The Apostle of Rest," by Dr. Roland Hammond.
"The Uses of Purified Human Fibrinogen and Thrombin in Medicine and Surgery," by Dr. Orville T. Bailey of Boston.
"Doctor, Your X-Ray Burned My Patient," by Dr. Philip Batchelder.
"Global Medicine," by Dr. Charles F. Branch of Boston.
"Medical and Dental Relations," by Dr. Albert L. Midgley.
"Manifestations of Disease of the Mouth," by Dr. Paul E. Boyle of Philadelphia.
"Some Practical Aspects of the Sterility Problem," by Dr. George W. Waterman—Dr. Earl B. Clarke discussed histological changes involved in various structures. Dr. Laurence A. Martineau discussed the X-Ray aspects of the Problem.

With the provision that interns who had completed service in local hospitals prior to enlistment could be eligible for membership in the Association, the total enrollment reached the highest in the history, with 573 active and associate members listed as of December 31, 1945. Seventeen members were elected to active membership, one to associate membership, and one member was reinstated. Three members resigned because of transfer of residence out of the state, one member was granted a leave of absence for postgraduate study outside the state, and two members were dropped for non-payment of dues.

During the year eight members died:

Harry Broadman (January 5)
Carl Doten (April 23)
Henry A. Lange (May 22)
Anna Topaz (June 19)
William S. Streker (July 8)
F. H. McCaffrey (July 21)
William Hindle (July 26)
Milton Korb (December 29)

With the cessation of hostilities on all the war fronts the Association has had the pleasure of welcoming back many of its members to civilian medical practice. As of December 31, approximately 41 members have resumed private practice. To publicize the return of these physicians and also to encourage their patients to return to them for medical care, the Association has initiated a series of paid advertisements in the *Providence Journal* under the direction of the War Veterans Committee of the Association.

During the year the Executive Committee has met regularly to conduct the business of the association and to carry on the many activities necessitated by the war effort as well as the reconversion to peacetime standards. The Committee recommended to the Association the formation of a War Veterans Committee through which the facilities of the Association and its membership could be placed at the disposal of returning physicians. The Committee also recommended the formation of a Committee on Smoke Abatement which has carried on a very successful public campaign to educate the people of Providence to the health hazards of smoke. The Association also in the course of the year adopted the resolution calling for state action to prevent the pollution of rivers of the state and of Narragansett Bay.

In October the Annual Golf Tournament and Dinner of the Association was revived, and it was considered one of the most successful affairs of its kind held at the Agawam Hunt Club with a large turn-out of members.

Through the generosity of former Presidents Emery M. Porter and Albert H. Jackvony, silk American and State Flags with standards now adorn the platform of the Medical Library Auditorium.

FRANK W. DIMMITT, M.D., *Secretary*

ANNUAL REPORT OF TREASURER — 1945

Providence Medical Association

RECEIPTS

Cash on Hand January 1, 1945	$2,513.09
Checks not cashed December, 1944	178.59
	$2,334.50
Check returned	15.09
	$2,349.59
Membership Dues	5,501.25
Dividends—U. S. War Savings Bonds	42.18
Checks not cashed December, 1945	398.00
	$8,291.02

Investments

U. S. War Savings Bond, purchased Dec. 1943	$ 740.00

continued on page 159



Illustrated is the sulfathiazole-frosted pharynx of patient A.K., *two hours* after Paredrine-Sulfathiazole Suspension had been instilled intranasally.

WHY SUCH RAPID RELIEF

TO OBTAIN BEST RESULTS . . . the sore throat patient should not eat or drink fluids for one or two hours after instillation of Paredrine-Sulfathiazole Suspension. He should also make every effort to reduce nose-blowing and throat-clearing to a minimum.

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There are two important reasons why Paredrine-Sulfathiazole Suspension—when administered intranasally—is so successful in the treatment of acute nasopharyngitis:

1. Part of the Suspension remains beneath the middle and superior turbinates—and, mixing with sinus drip, retards the proliferation of bacteria before they reach the nasopharynx and intensify the infection.

2. Part of the Suspension drifts downward over the nasopharynx, forming a fine frosting on the nasopharyngeal mucosa. This thin blanket not only keeps producing a bacteriostatic solution at the site of infection, but also appears to provide marked surface analgesia.

PAREDRINE-SULFATHIAZOLE SUSPENSION

vasoconstriction in minutes

bacteriostasis for hours

Hi Neighbor



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Narragansett Brewing Company, Cranston, Rhode Island

ANNUAL REPORTS

continued from page 155

U. S. War Savings Bond, purchased Feb. 1944	1,000.00
(Dividend Sept. 1944, March and Sept. 1945 $36.41)	
U. S. War Savings Bond, purchased Dec. 1944	1,000.00
(Dividends March and Sept. 1945 $19.68)	

EXPENDITURES

Collation after Scientific Meetings	$ 440.00
Telephone Service	160.98
Donation to Rhode Island Medical Society for use of Building	540.00
Medical Journals and Binding	498.31
Salaries	2,183.96
General Expenses	1,572.48
Collector of Internal Revenue	284.49
Insurance	238.08
Delineascope	191.00
Partial payment, Executive Secretary's expenses at A. M. A. Meeting and Secretaries' Conference	125.00
	$6,234.30
Cash on Hand January 1, 1946	2,056.72
	$8,291.02

HERBERT E. HARRIS, M.D., *Treasurer*

ENTERTAINMENT

The Committee on Entertainment of the Providence Medical Association herein submits its annual report.

We have arranged and provided for the collation following the regular monthly meetings of this association. We are particularly grateful to our executive secretary Mr. John E. Farrell for attending to the details of this function.

We are happy to announce that the institution of the annual golf tournament and dinner of the association has been resumed this year after several years' postponement during the war. This function was held at the Agawam Hunt Club on October 17, 1945. A record attendance of members and their guests was registered at the links as well as at the dinner. The President's Cup was awarded by Dr. Earl Clarke to Dr. Clifton Leech for low net score. Many prizes were awarded to members and guests, golfers and non-golfers alike. The performance of a professional entertainer was received with considerable enthusiasm and enjoyment. All comment received by your committee was most favorable.

The chairman wishes at this point to acknowledge with gratitude the cooperation of the individual members of the committee particularly Drs. Carl Sawyer and Ralph DiLeone for their untiring efforts and to Dr. Bolotow our perennial member ex-officio.

HERMAN P. GROSSMAN, M.D., *Chairman*
E. WADE BISHOP, M.D.
WILLIAM J. BUTLER, M.D.
RALPH DILEONE, M.D.
CARL D. SAWYER, M.D.

ETHICS AND DEPORTMENT

While no threatened suits for malpractice were presented during the past year, yet the Committee was active in three matters involving matters of ethics and deportment, each case arising from a different source. One investigation was the result of a complaint by a patient against a member who resorted to police force to eject the patient from his office. Another case involved a complaint by an insurance company against a member who had certified a patient as being unable to work who did work and collected compensation from the insurance company at the same time. The third case involved a member who was subject to public criticism in the daily press for action taken in an adoption case.

In each instance the Committee made complete investigations and reports.

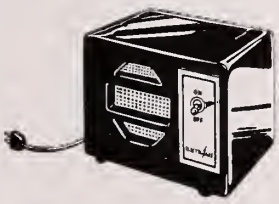
As the result of the varied problems that come before the Committee in the course of its work it is apparent that each member should be careful to keep clear and accurate records on every patient, should possess liability insurance for himself, and should be prompt in reporting to the Committee any threatened malpractice suit, or any attack upon his medical ethics.

HARRY C. MESSINGER, M.D., *Chairman*
ANTHONY CORVESE, M.D.
RUSSELL R. HUNT, M.D.
LOUIS I. KRAMER, M.D.
ANDREW MAHONEY, M.D.
HENRY B. MOOR, M.D.
WILLIAM S. STREKER, M.D.
JOHN G. WALSH, M.D.

BUREAU FOR HANDICAPPED

There have been no meetings in 1945 of the entire committee appointed by the Association to advise the Bureau for Handicapped which is now known as the Community Workshops, Inc.

continued on page 161



Ozone-Generator

The Ozone-Generator's activated oxygen, having three atoms to the molecule, really destroys all organic impurities (odors) in the air. Use it in office or home and odors just won't exist any more.

$23.50

6½x5x4½ inches

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PROVIDENCE

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"Bronchial Asthma ... etiology undefined"

In the paroxysms of bronchial asthma neither the physician nor his patient can wait for full identification of all asthmagens. *Without delay, symptoms must be relieved.*

PARASMA provides this rapid, symptomatic relief by the *oral* route. It is a synergistic combination of three principal oral antiasthmatics recognized individually in the *United States Pharmacopoeia.*

The combined PARASMA formula often succeeds where its components are ineffective singly, yet it does not involve the use of barbiturates, narcotics, pyrazolons or strychnine. On request, you will receive a free, full-size trade package of PARASMA for trial in your practice.

Parasma is not advertised to the Laity

Each PARASMA tablet contains ephedrine hydrochloride 1/8 gr., aminophylline 1 gr. and sodium bromide 3 gr. It is *indicated* in bronchial asthma to prevent or abort paroxysmal attacks and as a sustaining therapy.

PARASMA

DOSAGE: *3 tablets with water. Not to exceed 5 tablets in 3 hours or 10 tablets per day. Intermittent courses of 5 days per week recommended. Caution – too frequent or protracted use may lead to bromism or anxiety symptoms. Contraindicated in cardiac or renal disease, hyperthyroidism, hypertension or diabetes.*

HOW SUPPLIED: *Bottles of 24 tablets.*

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I am also interested in colonic constipation therapy. You may include corresponding material on EMODEX

Dr _____

Address _____

Town _____ Zone _____ State _____

ANNUAL REPORTS

continued from page 159

The Chairman has completed for the workshop papers which required the signature of a physician, has advised the Executive Committee of the workshop on a number of matters, and has attended meetings of the same committee.

Clifton B. Leech, M.D., *Chairman*
Katherine Cutts, M.D.
Raymond F. Hacking, M.D.
William A. Horan, M.D.
Louis A. Sage, M.D.
Francis B. Sargent, M.D.
Catherine Zouraboff, M.D.

NURSING

As in the past, the Committee on Nursing has had as one of its major functions that of serving in an advisory capacity to the Providence District Nursing Association. The counsel of the Committee has been mainly secured from the chairman, Dr. William Hindle, until his death in July. There has not been occasion for the Committee to meet formally, but on several occasions members have contributed information and advice to various problems concerned with nursing in the community when questions arose which were concerned with their special fields of medicine.

The Committee takes this opportunity to publicly express its appreciation of the service that Dr. William Hindle rendered to the various nursing organizations in Providence as the Chairman of this Committee for several years. His services have brought forth comments from many organizations.

William A. Hindle, M.D., *Chairman*
(Deceased July, 1945)
Paul C. Cook, M.D., *Acting Chairman*
Harmon P. B. Jordan, M.D.
James H. Fagan, M.D.
Charles Bradley, M.D.

PRE-SCHOOL EXAMINATIONS

As in previous years during the war the educational and organizational work of pre-school examination programs has been carried by the Providence School Department and the Parent-Teacher Association. Under the direction of Dr. Charles B. Lewis, director of health and physical education in the Department of Public Schools, and Mrs. E. Gardner Jacobs, Health Chairman of the Rhode Island Congress of Parents and Teachers, there has been no abatement in the efforts to expand this very important activity during 1945.

The general procedure has been somewhat as follows:

Early in February a letter and forms to be filled in with names of pupils who will enter school in September is sent to all elementary schools. These forms are filled in and are returned to the Health and Physical Education office before the end of that month. Then a letter is directed to each parent with the enclosure of pre-school forms which are returned to Mrs. Jacobs so that she may later organize members of the PTA to visit homes during April and May for follow ups to note whether the blank had been received, the examination made, what defects were found and if arrangements had been made for the correction of them. The school nurses also cooperate in the program in their visits to homes where there were children to enter school. During February and March effort is made to secure newspaper publicity to create public interest in the program.

The Committee of the Association serves mainly as an advisory group on the medical procedures involved in the pre-school roundup. During 1945 it was not necessary to hold any meetings. The results of the 1945 campaign will be tabulated and will be made public sometime in the spring of 1946.

Robert M. Lord, M.D., *Chairman*
Michael J. Nestor, M.D.
Harold G. Calder, M.D.
Charles B. Lewis, M.D.
Francis V. Corrigan, M.D.
Merle M. Potter, M.D.

READING ROOM

As in the past the Reading Room Committee has supervised the purchase of publications by the Association for use by members at the Medical Library. These excellent periodicals, available for use at the Library or on loan to any member, constitute a valuable reference file on current medical literature. The Committee urges members to utilize these publications when visiting the Medical Library.

Journals purchased during 1945, and available for reference are:

American Heart Journal
American Journal of Diseases of Children
American Journal of the Medical Sciences
American Journal of Obstetrics and Gynecology
American Journal of Ophthalmology
American Journal of Roentgenology
American Journal of Syphilis, Gonorrhea and Venereal Diseases
American Review of Tuberculosis
Annals of Surgery
Archives of Dermatology and Syphilology
Archives of Neurology and Psychiatry
Archives of Ophthalmology
Archives of Otolaryngology
Archives of Surgery
Brain
British Journal of Surgery
British Medical Journal
Bulletin of Johns Hopkins Hospital
Endocrinology
Gastroenterology
Journal of Bone and Joint Surgery
Journal of Experimental Medicine
Journal of Laboratory and Clinical Medicine
Journal of Nervous and Mental Disease
Journal of Pediatrics
Journal of Thoracic Surgery
Journal of Urology
Lancet
Medical Record
Medicine
Military Surgeon
Modern Hospital
Public Health Economics
Quarterly Cumulative Index Medicus
Radiology
Surgery
War Medicine

Edward S. Cameron, M.D., *Chairman*
Louis Goodman, M.D.
Francesco Ronchese, M.D.

TUBERCULOSIS

The Committee on Tuberculosis has had one meeting during the past year. The matters that came up for discussion were:

1. Whether or not personnel turned down or discharged by the armed services because of tuberculosis were reported to proper local health authorities.

continued on page 172

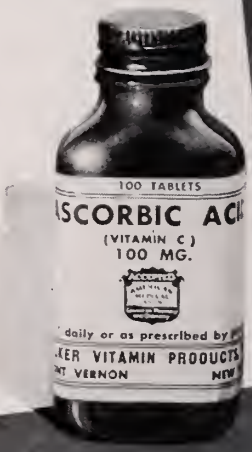


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The problem of securing high Quality Milk at seashore and country points is a difficult one.

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Fairoaks Farm	Fairoaks Farm	PE 6870
Hampshire Hills Farm	Whiting Milk Co.	GA 5363
Walker-Gordon Lab. Co., Inc.	H. P. Hood Co.	DE 3024
	Whiting Milk Co.	GA 5363

REPORT OF THE MILK COMMISSION OF THE PROVIDENCE MEDICAL ASSOCIATION

1945

Certified Milk in Providence during 1945 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Fairoaks Farm, Lincoln, R. I.; Hampshire Hills Farm, Wilton, N. H.; Walker-Gordon Farm, Charles River, Mass.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of two farms from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart. The potency test on the Vitamin-D milk was carried on in the laboratory of Dr. L. R. Parkinson of Massachusetts State College, Amherst, Massachusetts, and all three milks were found to contain 400 units per quart. These Certified milks are now modified by the addition of a vitamin-D concentrate.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

Much credit is due the management of these farms in keeping the standards of Certified milk on a high plane and these high ideals have been realized in spite of the acute shortages in materials and labor.

During the late summer one of the farms experienced some difficulty in keeping their bacteriological counts within normal limits, but after an intensive study by Professor Stuart's workers, it was found that by renewing the teat cups, which were made of synthetic rubber, the trouble cleared up rather quickly.

Now that more essential materials are becoming available on the farms it is hoped that all the farms can even better their excellent records.

During the past year the Commission has carried full page advertisements in the R. I. Medical Journal in an attempt to keep the "Quality Milk" before the medical profession.

The Commission is indebted to Dr. Edwin Knights, Deputy Inspector of Milk in Providence, for his continued interest and advice during the past year.

Harold G. Calder, *Chairman*
Reuben C. Bates, *Secretary*
Thomas J. Dolan
John Langdon
Frank I. Matteo
William P. Shields
Henry E. Utter
George W. Waterman
Raymond L. Webster, D.M.D.

MONTHLY AVERAGES OF CERTIFIED MILK FOR 1945

	CHERRY HILL H. P. HOOD			FAIROAKS				HAMPSHIRE HILLS			WALKER-GORDON		
	Pasteurized							Pasteurized			Vit. D. Pasteurized		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	Pasteurized	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	3.8	12.31	17	4.6	13.60	6,950	31	4.0	12.81	17	4.0	12.93	24
February	3.8	12.43	9	4.2	13.23	4,025	66	4.1	12.95	33	4.1	12.90	11
March	3.7	12.25	37	4.1	13.04	4,994	250	4.0	12.83	49	3.9	12.82	10
April	3.7	12.44	10	4.1	12.84	5,000	119	3.8	12.49	54	3.8	12.63	16
May	3.8	12.16	28	4.0	12.78	3,545	337	3.9	12.66	83	3.8	12.51	16
June	3.8	12.38	44	3.5	12.22	6,878	171	4.0	12.78	465	3.7	12.29	18
July	3.8	12.30	53	3.9	12.60	13,566	46	4.0	12.71	144	3.7	12.49	17
August	3.7	12.33	54	5.0	12.78	6,327	171	3.9	12.47	268	3.8	12.52	17
September	3.7	12.35	71	4.0	12.73	4,175	231	3.9	12.68	50	3.8	12.56	19
October	3.9	12.50	42	4.2	13.41	2,487	84	4.0	12.59	57	3.9	12.67	32
November	3.8	12.46	15	4.3	13.27	2,294	35	4.0	12.71	99	3.9	12.73	29
December	4.1	12.77	21	4.7	13.94	2,991	67	4.1	12.90	97	3.9	12.67	29
Yearly Average	3.8	12.39	33	4.2	13.04	5,269	134	4.0	12.71	118	3.8	12.64	20



in painful spasm . . .

Pavatrine with Phenobarbital provides both *neurotropic* and *musculotropic* spasmolysis—notably free from undesirable side effects—combined with mild central nervous sedation. Non-narcotic; orally administered.

INDICATIONS:

Gastrointestinal: cardiospasm, gastric hypermotility, pylorospasm, spasticity of duodenum, spastic states of colon

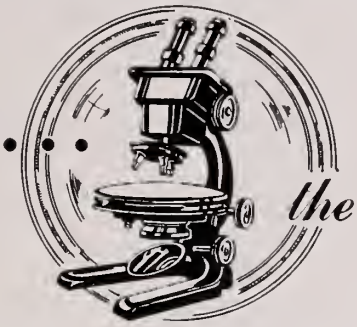
Dysmenorrhea: resulting from myometrial hypertonicity or excessive uterine contractions

Urinary Bladder: adjunctive therapy for relief of bladder spasm, whether due to a simple tenesmus, cystitis or mechanical trauma.

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SEARLE *Research in the Service of Medicine*

THROUGH . . .  *the Microscope*

THE WASHINGTON SCENE: The Hill-Burton hospital construction bill passed the Senate on December 12 with no outright opposition expressed at any time through its discussion on the floor. Senator Murray offered seven amendments but the only one accepted was that which provides a few more health centers than provided for in the bill. Referred in the House to the Interstate and Foreign Commerce Committee the act will be subject to hearings there this month * * * * * The Maternal and Child Welfare act, better known as the Pepper bill, will have plenty of support from women's clubs, P.T.A., and similar groups as the result of propaganda sent out by the Children's Bureau whose administering group of eleven women and two men, only three of whom are doctors, evidently see in it a continuance of the EMIC program under which a million wives and infants of servicemen have been cared for * * * * * In the 1944-45 period the EMIC expenditure in Rhode Island was better than $238,000 * * * * *

VETERANS: The passage of the bill providing for a new department of medicine and surgery in the Veterans Administration kicked up quite a controversy due to the provisions for appointment and discharge of doctors without Civil Service approval * * * * * The new hospital for veterans to be erected in Davis Park is slated to be a 418-bed general hospital for general medicine and surgery for which an appropriation of $3,404,222 has been provided * * * * * Many of New York City's doctors who gave up their practices to go to war were reported in the press to be enraged by rent gougers demanding exorbitant rentals for what few vacancies as existed * * * * * The study of the incidence of nervous conditions among World War II veterans recently carried on in Rhode Island with the cooperation of the medical society marks the first such survey in the country * * * * * We are still puzzling over a Veterans Administration ruling noted in our readings which read: "Part 25, (25.6060) 'At prescribed rates' the Veterans Administration may provide outpatient medical and dental treatment to employees of the Veterans Administration and to the families of such employees; also to the general public in emergencies. Published September 21."

MEETINGS: The American College of Physicians will resume its annual meetings with this year's session slated for Philadelphia from May 13-17, inclusive. Headquarters there will be at the Municipal Auditorium * * * * * When the AMA meets at San Francisco next July it will undoubtedly include a Section on General Practice since a resolution providing for such a grouping was adopted by the House of Delegates at the Chicago meeting in December * * * * * Dr. Roger I. Lee came up with a fine suggestion in his acceptance address upon his elevation to the Presidency of the AMA when he recommended that there be an additional mid-winter meeting of the House of Delegates of the AMA to permit a more careful study of organized medicine's problems * * * * *

PUBLIC HEALTH: Appointments to fill vacancies in the Reserve Corps of the USPHS are now being made, and examinations for Regular Corps appointments will be held in April and May * * * * * Physicians are needed immediately for duty in hospitals, in the tuberculosis and venereal disease control programs, and in other activities of the Service * * * * * Twenty-eight hospitals, totalling more than 26,000 beds, have been purchased by the UNRRA from Army surpluses in the United Kingdom and on the European continent and have been shipped to Poland, Czechoslovakia and Yugoslavia * * * * * Risk of introduction of an epidemic of malaria by returning soldiers from overseas is continually decreasing according to the Army Medical Corps staff leaders * * * * * Meanwhile the most important epidemic disease in Japan, according to reports by Japanese civilian officials to the Pacific office of the chief surgeon, U. S. Army, has been diphtheria * * * * * Tokyo City reported more than three thousand cases during the first eight months of 1945 * * * * *

continued on next page

THROUGH THE MICROSCOPE

concluded from preceding page

PRIZES: The American Physicians Art Association, with the cooperation of Mead Johnson & Company, is offering an important series of Savings Bonds as prizes to physicians for the best artistic works depicting the medical profession's "skill and courage and devotion beyond the call of duty" * * * * * An annual prize contest will be conducted again this year by the American Association of Obstetricians, Gynecologists and Abdominal Surgeons * * * * * A cash prize—not to exceed 500—is offered by the American Urological Association for an essay on the result of some specific clinical or laboratory research in urology * * * * *

WAR DOCTORS: By the first of the year the discharges of Army doctors were reported by the Office of the Surgeon General to be running far ahead of the schedule announced last September * * * * * It may be so, but we know of a good many of our doctors, some in far away spots, who would like the discharge schedule to catch up with them before they forget all knowledge of civilian medical practice * * * * * The 48th Evacuation Unit, which was composed chiefly of doctors and nurses from Rhode Island, won the meritorious unit plaque for services rendered to the Chinese Army in India from April to September, 1944 * * * * * Fourteen Army General Hospitals, including the one at Camp Edwards, will be closed March 31 according to present Army Medical Department plans * * * * * In World War I, 3,954 Army doctors, nurses and enlisted men of the Medical Department were killed or wounded. As of August 1, 1945, the Medical Department battle casualties were listed at 24,401 for World War II, with some 4,436 doctors, dentists, veterinarians, nurses and enlisted men killed, or dead of wounds, and another 605 listed as missing in action * * * * *

EDUCATION: Each new applicant for membership in the Los Angeles (Cal.) County Medical Society will henceforth be required to attend a course of lectures by qualified instructors, designed to augment his knowledge of California laws affecting the practice of medicine, of malpractice prophylaxis, of professional ethics and courtesy, and the Association's history, accomplishments and aims, and of other essential subjects * * * * * Meanwhile from Nashville, Tenn., we continue to receive brochures from a Dr. Cheatham extolling the opportunities of the Nashville College of Naturopathy * * * * *

IN PAWTUCKET IT'S . . .

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LEO C. CLARK, *Prop.*

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Vitamin B_1 (Thiamin HCL) (2666 U.S.P. Units)	8 Milligrams
Vitamin B_2 (G) (Riboflavin)	4 Milligrams
Niacinamide (Nicotinamide)	30 Milligrams
Pyridoxine (B_6)	2 Milligrams
Vitamin C (1500 U.S.P. Units)	75 Milligrams
Vitamin A	5000 U.S.P. Units
Vitamin D	1000 U.S.P. Units

Vi-teens Super Potency vitamin tablets are especially recommended in cases of avitaminosis where an unusually high dosage of additional multiple vitamin intake, particularly with reference to thiamin, riboflavin, and pyridoxine, is indicated. Regular size package on request.



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10 U.S.P. Units Per cc. 10cc Vial

Nikethamide
25% Solution Sterile Ampuloids 2cc. - 5cc.

Tablets Sulfathiazole
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Tablets Sulfadiazine
7.7 gr. (0.5 Gm.)

Tablets Phenobarbital
16 mg. 32 mg. 0.1 Gm.

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As vital as any ingredient written down is the skill with which a prescription is filled. Your patients can bring your prescriptions here assured that they will be compounded accurately by a qualified registered pharmacist — who uses only the highest quality drugs. Your patients get exactly what you order.

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Improved Adhesion

To prevent skidding of cars, sand or ashes are often sprinkled on icy winter streets. The physicist calls this improved adhesion between rubber and ice molecules. • WERNET'S POWDER accomplishes exactly this, when sprinkled lightly on dental plates. By providing a mucilaginous binder it prevents skidding of the dentures on the smooth gums, under the awkward manipulation of the new denture patient.

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• • In keeping with the importance of professional standards.

Decorous good taste plus comfortable, pleasant accommodations for patients — added efficiency for the doctor.

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The equipment that has the most to offer can do the most for you.

Install a Complete RITTER *Treatment Room with X-Ray*

Anesthetic Gases
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Across from St. Joseph's Hospital

Hospital Beds–Wheel
Chairs–Trusses–Belts
Supports–Sick Room
Supplies
PROVIDENCE

ANNUAL REPORTS

continued from page 161

2. Whether the cases of tuberculosis discovered on routine x-raying at Walsh-Kaiser were being followed.
3. Whether or not the present system of reporting tuberculosis in civilian practice was adequate.
4. Progress in industrial pre-employment examinations.

It was felt that the local induction authorities had been very cooperative in reporting their cases of tuberculosis, but that since the transfer of the induction center to Boston the reports had not come through so well and that for the men that had been discharged from service chief reliance for reports rested with the civilian physicians whom the discharged veterans consulted.

The cases found at Walsh-Kaiser have apparently all been reported and followed either by local physicians or by one of the tuberculosis clinics of the city or state.

In regard to the reporting of tuberculosis by civilian physicians, it was felt that frequently the physicians were remiss, and that some system to stimulate the reporting would be advisable.

It was the consensus of opinion that the blanks for reporting should be simplified and that one blank should be used for all reportable diseases. It was further suggested that some penalty might be imposed by proper authority on those who failed to comply with the regulations or some compensation provided for those complying.

In regard to pre-employment and routine x-raying in industry, Dr. Pinkney reported that the demand for the use of the mobile unit is becoming more general and that certain labor organizations are taking a more favorable attitude toward it than formerly.

JOHN C. HAM, M.D., *Chairman*
ROYAL C. HUDSON, M.D.
DANIEL A. SMITH, M.D.
PHILIP BATCHELDER, M.D.
KATHLEEN M. BARR, M.D.
CHARLES L. SOUTHEY, M.D.
PETER F. HARRINGTON, M.D.
UBALDO E. ZAMBARANO, M.D.
JAMES P. DEERY, M.D.

WAR VETERANS

Late in the Spring the President of the Association, by action of the Executive Committee, appointed a War Veterans Committee to assist the members of the Association returning to the district to resume private medical practice. The Committee consists of officers of the Association, as well as members, particularly suited to represent hospital, industrial health and veterans problems.

The chairman of the Committee, together with the executive secretary of the Association, attended a meeting with representatives of the U. S. Department of Commerce concerned with the disposal of surplus property. Information of interest to physician-veterans acquired as the result of this conference was passed along to each member of the Association in the armed forces. The chairman of the committee has endeavored to interview as many returning physicians as possible to offer each the full services of the Association.

In September the House of Delegates of the Rhode Island Medical Society acted favorably on the proposal stemming from this Association that a Veterans Service Bureau be established in connection with the executive office. As the result of this action the work of our committee has been closely allied with that of the new program whereby information of vital interest and value to doctor-veterans is disseminated through the executive offices. The success of this plan is best attested by the many communications received from members in the Services praising the efforts by the district and state organizations in their behalf, as well as the inquiries from other district and state medical societies that have learned of the work here.

To publicize the return to private practice of members the Association is purchasing space in the *Providence Journal* once each month wherein to list the name, office address, and office telephone of physicians resuming civilian work. The first such display appeared on Thanksgiving Day, the second on Christmas Day, and others will follow in Sunday issues of the paper during the coming months.

There are many problems facing the physician resuming private practice, ranging from the securing of malpractice insurance to the purchase of an automobile. Undoubtedly the most serious problem, however, is that of acquiring office space, and in many instances a family residence. The Veterans Bureau of the State Society, aided by our Committee, appealed to the realtors of the State and also secured a front page news story to publicize the problem. These actions resulted in the compiling of a file of possible sites for physicians' offices which was mimeographed and distributed to every war-doctor.

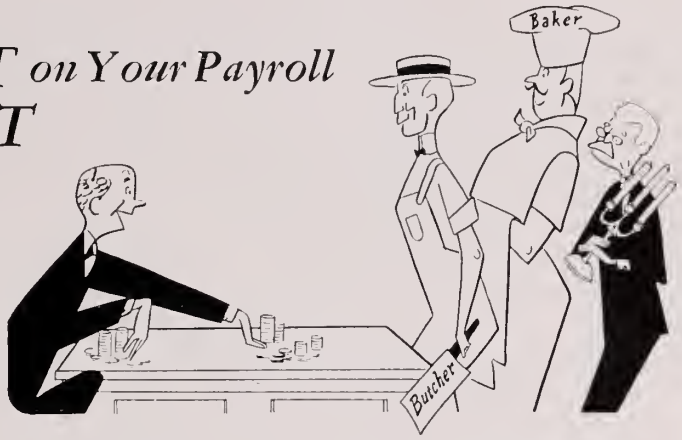
The Committee urges the members of the Association to continue their splendid efforts in behalf of the returning veterans, and it hopes that every member will continue to be cognizant of the increasing difficulties that will face the men yet to return—difficulties that will certainly call for the complete support of the Association for solution.

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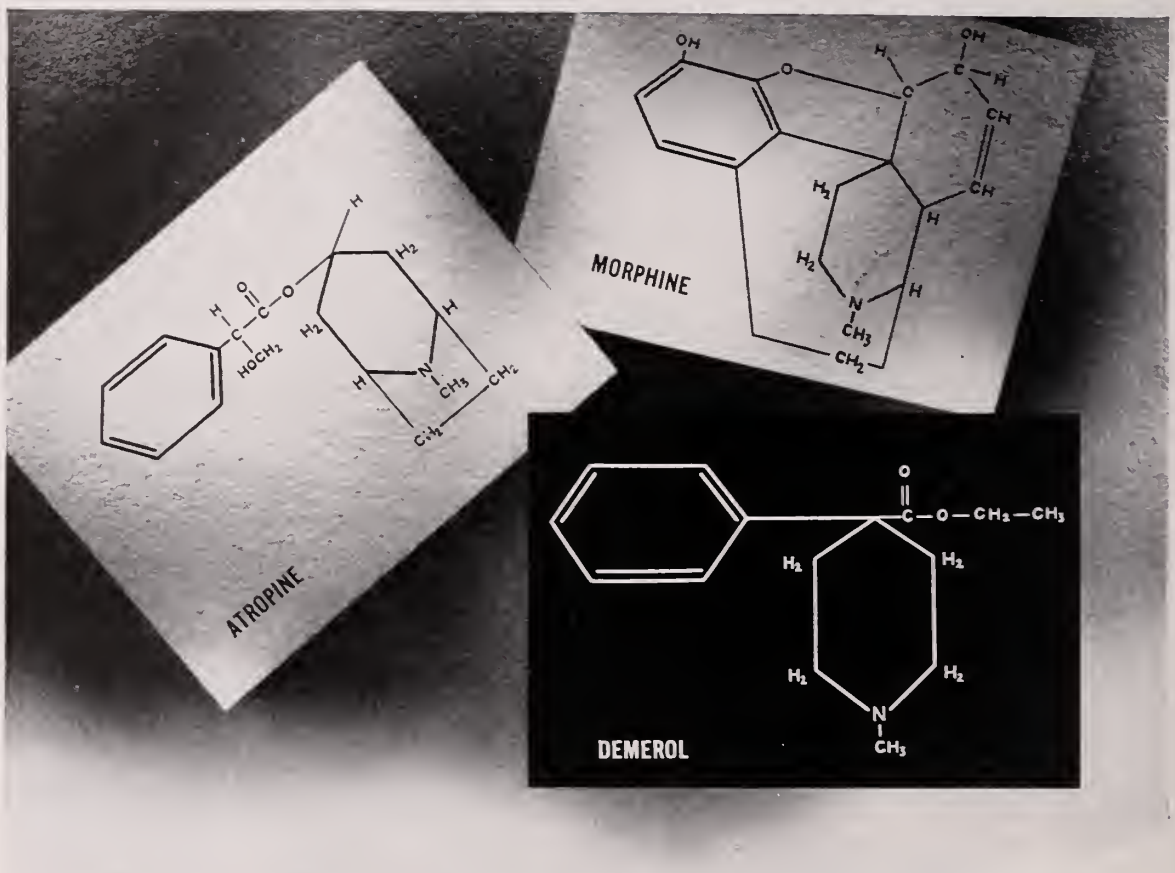
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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



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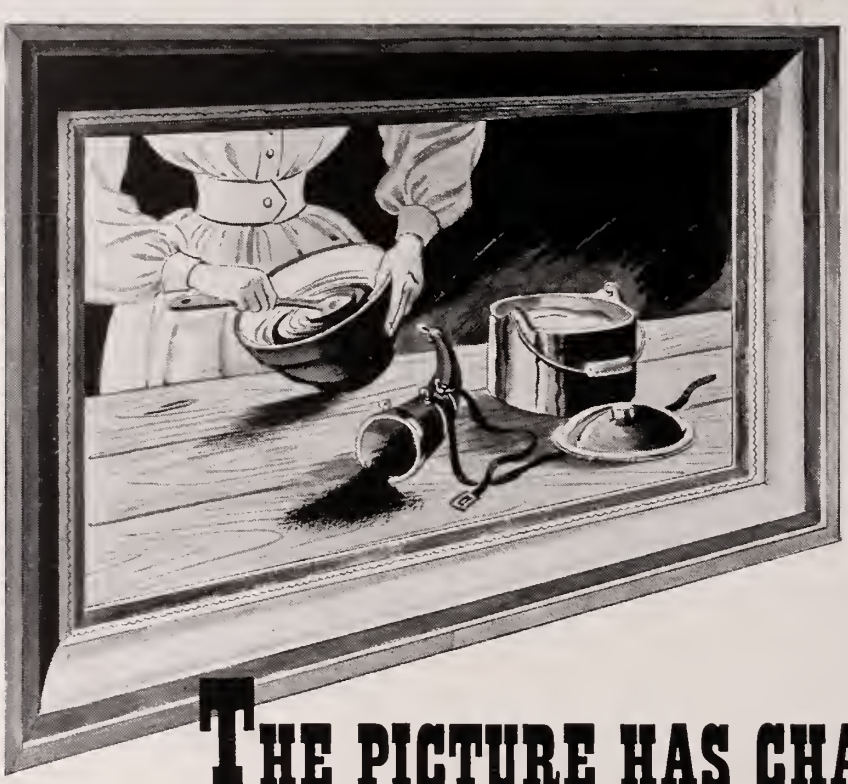
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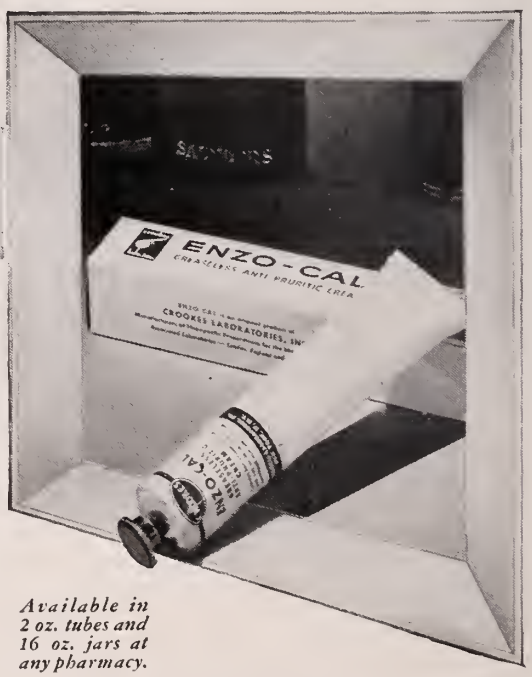
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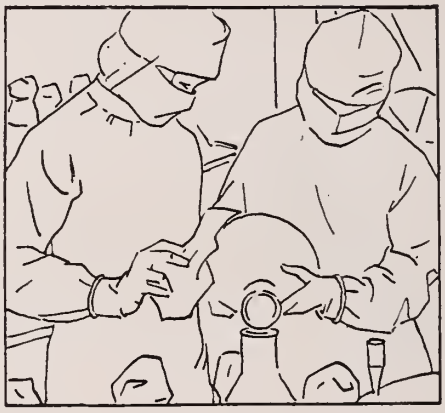
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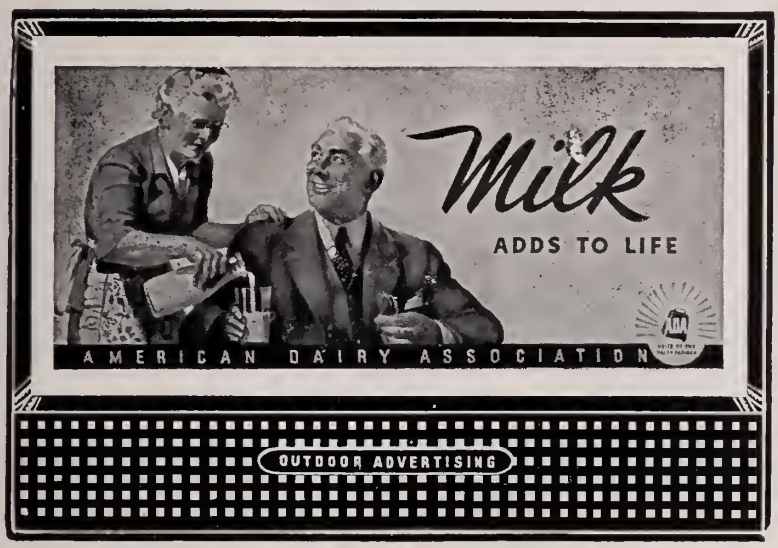
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The RHODE ISLAND MEDICAL JOURNAL

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THE PLAN FOR A VOLUNTARY SURGICAL INSURANCE PROGRAM FOR RHODE ISLAND*

HERMAN C. PITTS, M.D.

The Author. *Herman C. Pitts, M.D., of Providence. President-elect, Rhode Island Medical Society; Chairman, Surgical Insurance Study Committee.*

WHEN considering post-war problems, in his recent report to the Alumni of Yale University, President Seymour says "we must wisely steer a course between opposing attitudes: on the one hand the urge to a Tory complacency conceived in a nostalgic and unrealistic idea of the 'happier days of the past'; on the other hand, an equally unrealistic faith that novelties and hasty experiments offer the only solutions to the problems we have inherited from war and international revolution".

Although the problems confronting the medical profession are not necessarily inherited from war and international revolution, nevertheless President Seymour shows very plainly the course that must be followed by us if we are to maintain the high standards and the prestige that have always been ours.

It is perfectly evident that we cannot and must not think for a moment of allowing ourselves the pleasures of a "Tory complacency", neither should we sit supine while a noisy minority are clamoring for the introduction of "hasty experiments" which we in our hearts feel will result in giving the American people a larger quantity of medical care perhaps, but of such a lessened quality that they will be the poorer for it.

Hasty experiments! How dangerous they are to the whole social structure! 'Tis a great pity that everyone who seeks to enter national political life is not required to specialize in history both ancient and modern. Perhaps he might even be made to pass an American Board of History to parellel what the medical man must do to qualify as a specialist in any branch of his profession.

Such study would at least teach him that there are certain fundamental laws of human nature and human relations that are not to be gainsaid.

History repeats itself and human nature does not change.

The Roman Empire fell largely because the Roman people were allowed to imagine that they could attain security in living through a blind dependence on Government.

Government would think for them. All they had to do was to open their hands and they would receive.

The inevitable result was the loss of individual initiative and the will to defend what was theirs. When the crisis came and the hordes of barbarians were hammering on the gates of Rome, that loss of initiative plus their dependence on Government made them totally incapable of making a united and determined effort to defend the glory of Rome which was theirs, and in consequence the greatest civilization that had existed up to that time, fell in ruins about them.

Ah, but, the Brain Trust says it is utter folly to compare our wonderful modern civilization with that of Ancient Rome. Superficially it is. Fundamentally there are similarities that make one ponder. At any rate the uplifters are trying to do to the American people exactly what the Roman Emperors did all too successfully to the Roman people. They are again holding out the bait of security. Not this time in the guise of doles and bread, but in the promise of security in childhood, security in sickness, security in old age, security in everything from the cradle to the grave.

When all the while they must know, if they know only the A.B.C. of human nature, that the only security there is for us humans lies in the individual's determination to think for himself, to act for himself and to provide for the accidents of the future by himself.

Human nature has not changed one iota since the days of Ancient Rome and the same effort to

continued on next page

*An address delivered before a joint meeting of the Rhode Island Medical Society and the Providence Medical Association, at Providence, February 4, 1946.

paternalize our government in this 20th century will have the same disastrous effect on the character of our people as it did on those other people centuries ago.

We have it from Senator Wagner himself and from President Truman that the proposed expansion of the Social Security Act will not socialize medicine but we as physicians know perfectly well that any such talk is pure whitewash. Even if we could kid ourselves into the belief that such legislation would not socialize, would not lower the general level of medical practice, every thinking man and woman among us should oppose it on grounds not directly connected with his profession. First and foremost we should oppose it on the grounds that it would lower the level of morale of our whole population. We have had an example of this on a small scale here in Rhode Island where the Cash Sickness Fund is looked upon by the large majority as a sort of savings fund account that can be called upon whenever one is tired of working and feels the need of a vacation. Since the money is taken by compulsion, they quite naturally feel it is rightfully theirs, wrongfully held and they mean to have as much of it back as possible whether rightfully or wrongfully!

The same thing will happen on a much grander scale if any of the bills aimed to uplift (?) the people of these United States is passed.

Secondly, we will have the greatest bureaucracy saddled upon us that the country has ever known and our experience of the last few years has given us more than a taste, rather a huge mouthful of what that means.

Thirdly, the cost, two (2) billion dollars is quite a sum of money. If the ordinary working man knew that even this huge sum will probably not be enough to carry the benefits offered and that he may face a pay envelope reduced not by 4 but even by 6 or 8%, he would not be so inclined to authorize his Union to vote for and urge the passage of such legislation.

What can we, a small group, do to prevent the passage of legislation that we in our hearts believe is detrimental to the future of the whole nation? Two courses are perfectly apparent—the one a sort of negative activity, the other an active effort to arouse the somewhat somnolent desire of our people to stand on their own feet and to think and act for themselves.

If we choose the first course, and it certainly is the simplest and most primitive, all we have to do as a profession is to make it be known that we will refuse to participate in the operation of the scheme. For of course without the active participation of considerably over 50% of physicians no such plan could succeed.

The great difficulty in carrying out this form of opposition lies at the very roots of our existence as physicians. We are here to treat the sick whenever they come to us and whatever their position in the social scheme.

Of course we could treat the sick who are entitled to benefits under Social Security and refuse to send Government a bill for services rendered. But here alas, economic necessity steps in to put a damper on any such visionary plan.

The second way in which we can attack the problem is not one of frontal assault, not one in which we just refuse to "play ball".

It requires just the same unanimity of action on our part and is based on a direct appeal to that independence of spirit we must believe still exists in the heart of the average man. By offering him an opportunity to provide for catastrophic illness through a system of voluntary insurance for which the medical profession is primarily responsible, we have every reason to believe that much of the thunder will be taken from the dark clouds of the socializing storm that hovers over us.

Believing firmly that "the medical profession of Rhode Island has always been receptive to any sound and progressive program for the improvement of the health of the people of this State and for the better distribution of the costs of medical care", your House of Delegates took the first step on the road toward the formation of a voluntary, pre-paid medical-surgical plan by having an Enabling Act presented to our legislators giving the Rhode Island Medical Society sole right to incorporate such a non-profit organization in the State.

Section 9 of this Act is important, because it allows any non-profit Hospital Service Corporation duly organized under the laws of the State "to take over all of the duties and responsibilities of a non-profit Medical Service Corporation".

More on this Section later.

To further a plan of medical-surgical prepaid voluntary insurance, a committee of six (6) doctors was appointed to study existing plans and to make recommendations, these six to invite five (5) prominent public-spirited lay-men to sit with them in their deliberations.

It is fitting at this point to express publicly our great indebtedness and sincere thanks to these gentlemen who gave lavishly of their time and thought to the problem. Without them much more time would have been consumed in reaching any conclusion.

It would be unprofitable to report in detail the discussions that led to the final report of the Committee.

However, certain items in those discussions are important.

First of all the opposition in the Committee to the wording of Section 9 of the Enabling Act, which as you remember, allowed the Rhode Island Medical Society to delegate *all* the powers invested in it for the establishment of a non-profit Medical Service Corporation to an already existing non-profit Hospital Service Corporation—referring of course to Blue Cross.

Certain members of your Committee felt that by allowing this to pass the medical profession would lose all control of medical policies in the operation of the plan in case Blue Cross was asked to take it over. They therefore recommended that the Section be amended to read "all or *part* of the powers". However the Legislature passed the Act as originally worded and there was nothing much we could do about it.

Very early it was voted to confine our efforts to planning for surgical and obstetrical benefits in the hospital only with the idea that as funds accumulated we could extend the benefits to embrace a wider field—such as surgery in and out of hospital and purely medical benefits under certain specified conditions.

It was recommended that there should be an income limit—$2500 for individuals, $3000 for a family, below which limits sums paid by the Corporation as set forth in a fee table published by the Medical Society must be considered as payment in full for the service rendered. On the other hand individuals and families in the higher income brackets could be charged more at the discretion of the attending surgeon and the sum paid by the Corporation be considered only as an indemnity.

The House of Delegates has voted to change the income limit to 2000 dollars for a single man or woman, 2500 for man and spouse with 300 dollars added for each dependent child.

The committee was unanimous in its opinion that no plan could be successfully run without the co-operation of Blue Cross. Their wide experience in merchandizing and administering hospital benefits seemed essential to success. It was unthinkable to your committee that a group of busy doctors could spare the time, nor had they the necessary training to take on such a task.

The degree of our participation with Blue Cross was under considerable discussion. It was not until a sub-committee appointed to examine what our relations with Blue Cross should be, had presented its very able and logical report that we could vote unanimously to recommend that Blue Cross be asked to take over the complete running of our surgical benefits plan, reserving for ourselves a measure of medical control through a small arbitration committee appointed by the Rhode Island Medical Society to pass on problems purely professional.

The House of Delegates would not accept these recommendations and so we seemed to have reached an impasse. Fortunately the door for compromise was left open a crack by an unoffiicial suggestion that Blue Cross might be induced to give us increased representation on their Board of Directors.

Another meeting and it was found that Blue Cross was willing to accept medical men appointed by the Rhode Island Medical Society on its Board in the proportion of one in every four members. This should give us a real say in the development of policies when the plan begins to operate.

There is much detail to be worked out, such as the form of contract with the subscribers on the one hand and the participating physicians on the other. Then a fee table must be prepared by a committee of the Medical Society.

In the main our plan will be modeled a good deal on the plan that has worked so successfully in Delaware.

The financing of the Plan is of paramount importance. Blue Cross will of course have to be re-imbursed for the merchandizing and the operation of the Plan. It is possible this can be done from the beginning through subscribers payments only, provided participating physicians will be willing to wait for payment for services rendered until the reserve in funds is sufficient. On the other hand loans from the doctors of the State may be necessary to launch the plan successfully.

Costs at any rate must be kept at a minimum. If the Plan is to succeed at all it must be able to compete with commercial insurance companies on a basis of cost and the size of benefits.

Above all there must be sympathetic understanding between Blue Cross on the one hand and the medical profession on the other.

The plan once launched, they are just as anxious to have it succeed as we are. We ask them for the help of their experience. We must be willing to listen to their advice in the operation of the Plan. On the other hand there are certain professional rights and professional standards we mean to maintain. Our representatives on the Board of Directors will be expected to see that the rights are recognized and the standards maintained.

Finally and most important whatever the mere details of the Plan as finally adopted, its successful operation depends entirely on the attitude of the medical profession of the State. If they accept it whole heartedly as a public service, as an honest attempt to give our citizens help in time of need and at a cost they can afford, then it will steadily increase in usefulness and will become one more barrier erected by us opposed to the regimentation not only of ourselves but of the public, that is most certainly in the offing.

THE INJECTION TREATMENT OF HEMORRHOIDS

THAD A. KROLICKI, M.D.

The Author. *Thad A. Krolicki, M.D., of Pawtucket, R. I., Surgeon, Outpatient Department, Memorial Hospital, Pawtucket.*

THE general practitioner of medicine who meets with the problem of treating hemorrhoids, naturally, pauses for a moment to reflect upon his fund of knowledge on the subject. As he reflects, he becomes dimly aware of the fact, that in the main, this consists of broad generalizations which help him but little in the particular case awaiting his treatment. In an effort to supplement his general knowledge on the subject, he may turn to the literature for assistance. Here he will find himself in the deplorable dilemma of choosing between text book opinions, some of which are archaic, and current literature articles which, in their enthusiastic support of some therapeutic fad, are radical if not actually fanatical.

Obviously, therefore, an unprejudiced evaluation of a method which, after fifteen years of trial, is at present being used, is to be welcomed. A digest of present concepts as to treatment of hemorrhoids, as practiced in the Rectal Clinic of the Massachusetts General Hospital, is attempted in this monograph.

General Considerations

By many, hemorrhoids are generally considered as a purely surgical condition. All too frequently, they are considered as a disease entity, while as a matter of fact they are ordinarily a result of disturbed physiology which covers a very wide range of general, as well as local pathology. Hemorrhoids occur usually after the second decade of life and are rather common in thin individuals. Whether or not heredity is a factor, is not definitely established.

The recognition and approbation of the injection method for treating hemorrhoids is the culmination of a long and valiant struggle on the part of the few who discerned its inherent value. The originator of the method in this country was Mitchell[1] of Clinton, Illinois, who, in 1871, adapted to his own uses, the discovery of Morgan, of Dublin, Ireland. He seemed, however, to care little for actual results and gave no study or thought to further development of this procedure or to proper instruction of those who wished to practice this therapy. For this reason, the treatment, being exploited throughout the country by itinerant charlatans and untrained practitioners, fell into disrepute. It took many years of firm faith, assiduous labor, and widely disseminated literature to restore the tarnished reputation. For this, Andrews[2], Tuttle[3], and Kelsey,[4, 5] should receive most credit. It is largely through their efforts that the injection treatment of hemorrhoids has attained a definite place as an ethical and scientific procedure. This therapy today is held in high esteem by many leading proctologists in this country and abroad. In selected cases it is recognized as an adequate means of treatment and besides being effective it is relatively painless, and the patient remains ambulant.

Most of the contrary opinions are based on adverse results which sometimes occurred, with complications, such as sloughing, abscess and fistulae. These have been eliminated to a great extent by perfection of technic, but the greatest factor in obtaining satisfactory results is the proper and discriminating selection of cases. According to Martin[6], approximately 50 percent of cases of internal hemorrhoids are suitable for injection; and Dukes[7], of London, has answered practically every known controversy in his review of this therapy. The great misfortune is that those not properly schooled in the anatomy of the anorectal region, or skilled in this technic are prone to inject hemorrhoids indiscriminately. Unsatisfactory results, complications, and even failures may be expected in the wake of incorrect diagnosis, indifference to contraindications, and faulty technic.

Refinement in the technic of injection of internal hemorrhoids as practiced in the Rectal Clinic of the Massachusetts General Hospital, is best described by Hayden[8]. Reviews of the results in the Rectal Clinic of the Massachusetts General Hospital, from 1930-1939-1945, have been studied and reported by Balch[9], Mabrey[10], and Spear[11].

Selection of Cases

Yaker[12, 13] has struck a sensible note regarding this subject. He states there is no reason for arguing whether surgical removal or the injection of sclerosing agents is the better form of therapy for internal hemorrhoids. He believes that there

is ample reason for utilizing both methods, since good results are obtained by each. The essential thing is to recognize the fact that injection treatment should be chiefly reserved for uncomplicated and moderate internal hemorrhoids, whereas the so-called "mixed type" and the advanced cases should usually be operated on.

Initially, it is paramount that the proper type only be injected. It is advisable that the patient understand the limitations of this form of treatment. Internal hemorrhoids only should be thus treated. Hemorrhoids of the internal variety, when small or of moderate size and uncomplicated, are suitable for the injection treatment. This form of therapy is contraindicated, however, in all external hemorrhoids; where considerable fibrosis exists; or where thrombosis, strangulation, or ulceration has occurred; also in the presence of a markedly contracted sphincter; and where associated pathology exists, such as fissure, fistula, pelvic tumors, cryptitis, proctitis, and phlebitis. If a fissure or fistula are present and require surgery, surgical removal of the hemorrhoids is best accomplished at that time. Every case of rectal bleeding should be proctoscoped and if indicated studied by other methods. The anatomy of the anus and rectum as described in various books of anatomy needs no elaboration here. History of bleeding from rectum after bowel movement, in form of bright blood, staining the bowl, or wiping tissue; protrusion from rectum after bowel movement; a sense of incomplete evacuation; discomfort in rectum and at times an unexplained backache suggest a direct physical and clinical examination of the rectum and a proper diagnosis of internal hemorrhoids.

Equipment

The only instruments necessary are a suitable anoscope, a syringe and needle, a sclerosing solution and a good light. At the Rectal Clinic of the Massachusetts General Hospital, a small fenestrated Otis anoscope, a 5 cc. Luer lock type syringe, and a one and a half inch 26 gauge needle, and an ordinary student's reading lamp on a stand are preferred, and have been proved to be very satisfactory. The sclerosing fluid used is a five percent quinine and urea hydrochloride prepared in bulk. In private practice it is best used in sterile ampules containing 2 cc. each. Quinine and urea hydrochloride was first introduced by Terrell[14, 15] in 1913 and has given excellent results. Fansler[16] finds five percent phenol in Olive or Wesson's oil to be most satisfactory. Rosser[17] states that, in his experience, phenol, even when dissolved in glycerin, must be limited to a few minims if sloughing is to be avoided. All strong fluids cause sloughing. The selection of a sclerosing fluid is important in the injection of internal hemorrhoids. Tuttle[18] says: "The principle upon which this method is based consists in the production of an inflammatory induration of the hemorrhoidal mass, through which the circulation is retarded or partially cut off, but which does not go to the extent of cauterization or strangulation so as to result in sloughing."

Technic of Injection

The patient lies in the right Sim's position, and with his left hand elevates the left buttock, thus facilitating exposure of the anus. The operator sits on a stool at the side of the table facing the patient's buttocks, his line of vision, being level with the operative field. A student's lamp placed between the operator's feet and reaching the level of his chin supplies adequate illumination.

Digital examination is first performed, using the left index finger covered with a rubber cot and well lubricated. If an inflammatory lesion is found, such as a fissure, fistula or acute cryptitis, no injection should be carried out until these have been corrected. Uncomplicated internal hemorrhoids are not as a rule palpable by digital examination.

A fenestrated Otis anoscope, well covered with a greasy lubricant, is next introduced into the anus, and is pushed in as far as it will go before removing the obturator. This is necessary because in many cases the mucocutaneous line is deeply placed. This line can be readily identified by the alternating papillae and crypts about 2 or 3 cm. from the anal margin. If an internal hemorrhoid is present in that quadrant, it will bulge into the fenestrum of the speculum.

The hemorrhoid is wiped with a dry swab and cleansed with soap solution. Complete sterilization is impossible, and the use of iodine or other antiseptics is unnecessary. The danger of infection is negligible. We have not seen an abscess result, despite insufficient sterilization of the area of the needle puncture. In the presence of known infection, injection should be postponed.

Using a 5 cc. syringe filled with a solution of 5 percent quinine and urea hydrochloride and fitted with a 26 gauge needle 4 cm. long, the hemorrhoid is punctured and 1.0 to 1.5 cc of the solution is injected directly into the center of the hemorrhoidal mass at a depth of 0.3 to 0.8 cm. from the surface of the mucous membrane, according to the size of the hemorrhoid. The needle puncture should be made 0.6 cm. or more above the mucocutaneous line, and care should be taken not to inject either the submucous area, the outer wall of the bowel or the pararectal tissues. Submucous injection is likely to result in a slough, while injection thru the bowel wall or pararectal tissue may produce a serious infection in the pelvis.

After the injection is completed, the obturator is replaced and the speculum removed. If neces-

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sary, this procedure is repeated until all four quadrants have been injected.

Most patients have an uncomfortable ache or a sensation of fullness in the rectum starting ½ hr. following injection. This may last from thirty minutes to one hour. In most instances it is not actually disabling. Injections are repeated at weekly intervals until the main symptoms of bleeding stop. Protrusion usually does not recur after one or two injections; the treatment, however, should be carried out for three or four weeks unless palpable fibrosis or slough results. In this case only the hemorrhoids not indurated should be injected. The patient is ambulatory during the treatment.

Advantages ond Disadvantages

The advantages have already been touched upon lightly. The method requires no anesthetics and is economical to the patient. It is an ambulant procedure and therefore does not necessitate hospitalization. No period of disability should occur; in fact complications are comparatively few and of less import than postoperative sequelae. Without risk, this therapy can be utilized in pregnancy, diabetes, and old age, as well as in cardiac, renal and pulmonary diseases. Relief of symptoms varies in length of time. It is dependent on the number of injections, and on the size of hemorrhoid, and other various factors.

Although few, the disadvantages may be enumerated as follows: (1) limitation of the treatment, in that not all hemorrhoids are suitable for injection; (2) frequency of recurrence, estimated at approximately 15 percent in from two to five years[19, 20] and (3) the misfortune that the procedure is so often performed by the unskilled, with the result that the complications arising are not only disheartening to the proctologist, but at times hazardous to the patient.

With experienced operators, careful selection of cases, and meticulous preparation of the solution, complications are today comparatively rare. At times a sensation of heat or slight fullness exists for a few minutes, but rarely does it continue for more than thirty minutes to an hour. Pain of a burning or stinging character occurs where the injection is made too close to the anorectal line or where too much solution is injected. This may continue for several hours. Of course the injection should not be made when the mere insertion of the needle is attended by pain; but, if the solution has been deposited, hot compresses and sitz baths will prove of value. In an exceptionally small proportion of cases, idiosyncrasy to quinine will be noted (1 percent), but this should not deter the expert physician from using the drug as a routine procedure.

Marked bleeding never occurs unless sloughing takes place, although slight oozing is not uncommon. In part this may be avoided by withdrawing the speculum at the same time as the needle. This relieves the tension placed upon the hemorrhoidal mass by the walls of the fenestrum of the anoscope and permits the rectal walls to collapse, which serves to exert slight pressure and thereby prevent bleeding. Sloughing is relatively uncommon, except when the procedure is performed by the unskilled. Usually it is due to the use of a too-strong or an excessive amount of solution, or to making the injection too close to the anorectal line. As a remedy, the instillation of warm olive oil may be used with satisfaction. In these cases bleeding is not infrequent, and pressure with a plug of boric acid gauze or even ligature may be necessary. By some, sloughing is considered a minor sequel, but it should be avoided, since complications of a more serious nature may ensue, such as ulceration, proctitis, stricture, abscess, and fistulae. Where contraindicated, the injection method should by all means be avoided, but in selected cases it is a facile, relatively painless, and satisfactory procedure.

Summary

A brief resume of the history of injection of hemorrhoids is presented. General considerations of pathology and method of selection of suitable cases are reviewed. The equipment necessary for this type of treatment and the technic of injection as used and performed at the Rectal Clinic of the Massachusetts General Hospital is described. Advantages and disadvantages of this method of treatment are summarized.

Conclusions

The injection treatment of internal hemorrhoids can be satisfactorily carried out in about fifty to ninety percent of the cases seen and examined.

Selection of cases is a major consideration. The treatment is practically painless and devoid of serious complications in the hands of expert operators. Injection will cure the symptoms of internal hemorrhoids, namely bleeding and protrusion. The cure may be permanent depending on the number of injections, and the size of hemorrhoid. A recurrence may be expected in two to five years, which may be relieved by subsequent injection. In selected cases it is a facile, relatively painless, and satisfactory procedure. Patients are satisfied with the results.

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MEDICAL CARE FOR THE VETERANS*

MAJOR GENERAL PAUL R. HAWLEY, MC

The Author. *Major General Paul R. Hawley, MC, of Washington, D. C. Assistant Administrator of Veterans' Affairs, in charge of Medicine and Surgery, U. S. Veterans Administration.*

I SHOULD first like to say that I am personally very sorry to hear that your President is ill and unable to be here tonight, but that his deputies have outdone themselves in hospitality since I have arrived in your state and city. It is a privilege to meet with this distinguished group. Today — this morning — for the first time there appeared in my office due to delays in mail the JOURNAL of your State Society, and I cannot tell you how flattered I am to have been so honored in this issue. It is a pleasure to meet this group — with a group that can understand the medical problems of the veterans. I have to meet with so many groups, fortunately much smaller than this, that are unable to understand these problems as only a doctor can understand them. Finally, it is always a cause for celebration for any of us to get away from Washington.

Now it seems to me that our problem in the medical care of the veterans is so simple that it can be thoroughly understood by any twelve-year old child, and to show you how simple that it is, I am going to speak as I would perhaps to a twelve-year old child. Despite the great numbers of perfectly splendid doctors that have spent years in the service of the veteran in the Veterans Administration — and let no one in this audience think for one minute that there are not today and have not been for a number of years as fine, well-trained and competent men in the service of the Veterans Administration as you will find in any group of medical men in this country, — the evils that have grown up in the medical service were almost entirely beyond the control of this group of men. I should like here publicly to express my deep appreciation of the way this fine group of men in the Veterans Administration have received me—a rank outsider—who should and could have been received with suspicion. They welcomed me because they have realized that it was going to require someone from the outside to correct these evils. The system had so restricted these fine men that they had grave doubts that anyone in the service could correct them; and furthermore, they realize, and I want you to realize, that other than to serve the veteran this job means absolutely nothing to me. The only thing that can be done to me is to send me back to the Army. And so these good people in the Veterans Administration realize that I have no personal ambitions, and perhaps it does take someone with the background that I have to help them; and they will realize more and more that my sole aim, next to helping the veteran, is to help the doctors who will help the veteran.

So the first proposition is that the veteran never has on the whole received perhaps the standard of medical care that he has earned, and that the people of the United States for the most part have all these years thought that he was getting.

The second part of the problem is that, when the facts were known to the people, they immediately demanded correction and the highest possible standard of medical care for the veteran.

Third, it was never possible under the existing organization and administration to give that high standard of care with a completely full-time medical service when there were only four million veterans to care for. Under a more sympathetic and more understanding direction it might have been possible to provide a medical service of acceptable standards for four million veterans. But I rather question that, with the competition of other public services and the temptation of private practice, it could have been wholly possible. It certainly was impossible under the completely unsympathetic management of the medical service of the Veterans Administration by those in authority.

Fourth, one has only to know a very little about the present medical situation in the United States to realize that it is impossible to provide any kind of medical service for twenty million veterans with a completely full-time medical staff. With the proportion of doctors to the population as a whole decreasing steadily each year, with the policy of Selective Service of not exempting enough men to keep a steady flow in the medical profession, there

continued on next page

*An address delivered before a joint meeting of the Rhode Island Medical Society and the Providence Medical Association, at Providence, February 4, 1946.

will result some very lean years soon. It would be tragic to attempt to solve a problem like this on the basis of a completely full-time medical service.

Fifth, we must plan to provide a considerable part of this service with part-time physicians.

Sixth, to insure the highest standard of medical care for veterans we must raise our hospitals to the standard required for approved medical training. That is in itself the hall-mark of the medical profession. While we are interested in medical education we are not establishing residencies primarily to permit the training of physicians. We are establishing them primarily in the interest of the patient. We know that when resident physicians are approved in our hospitals the patient is getting the highest standard of medical care that can be given in this country.

Now let us pause and summarize these six problems which confront us. We can digest these into two or three sentences. We must raise the standard of our hospitals to the required standard for resident training. We must afford the veteran the service of fully qualified specialists whenever he needs such service. We must depend in large part upon part-time physicians for specialty care, because we can never hope to attract enough full-time men of the required caliber. You will be amazed at the quality of the men we are now attracting, but we can never attract enough men with these qualifications to give all of their time to the veteran. Since those are our requirements, where do we find highly trained specialists in numbers? In the woods? Do we find them in small hamlets and villages and small towns? No reflection on small towns — my grandfather and my father practiced medicine in a small town — but you don't find highly-trained specialists in these places. If we are forced to depend on part-time specialists, where should we build our more important hospitals? Now that is the question, and when it is explained in this simple language do you think that there is any twelve-year old child in this State or in this City that wouldn't give the right answer?

Someone called upon me in my office to persuade me to take over one of the Army general hospitals. They told me how much this hospital cost. I agreed. They told me in what a wonderful agricultural part of the United States this hospital was located. It was about seven miles from a town of 5,000. They told me how many veterans came from that part of the country. I agreed. They told me that they couldn't understand how anyone in their right mind would turn down this hospital, which was a 2000-bed institution. I said to them, "I should be glad to operate this hospital if you can tell me where I can get a staff for it." That question was evaded. Then the description started over again. They told me how much this hospital cost and in what a wonderful part of the United States it was located. Each time they paused for breath I would say, "Tell me where I can get the staff to operate this hospital?" This question is still unanswered.

When General Bradley and I came to the Veterans' Administration the first requirement was perfectly obvious. We had to have a good organization to start with. It was silly for me to mount a horse and gallop off in all four directions trying to accomplish something. You can't do much except make a lot of fuss when you are trying to start all alone. We had no organization in the medical service at all adequate to expand and improve the standard of the service.

The second requirement was to plead for and get the help of the medical profession, the cooperation of the schools of medicine and the medical centers such as are here in Providence, because we couldn't possibly solve this problem without help. The medical profession of this country was frankly skeptical whether anything could be done with the medical service of the Veterans Administration and they were not altogether ready to help unless they could help under conditions they could accept. I shall never forget my first appearance before the Board of Trustees of the American Medical Association. From that start each successive appearance before the governing bodies of the AMA was more and more cordial, and I was deeply touched by the reception the House of Delegates gave me in December. I felt that at that time we had the cooperation and the approval of the medical profession of this country and it was distinctly up to us to keep it.

The third requirement was some change in the laws and legislation so that we could offer good doctors more money. Congress changed the original draft of that bill many times. My only fight was to preserve certain provisions in that bill, in particular to encourage every man who comes into the Administration to improve himself. So we gave 25 per cent increase in his pay for certification by a Specialty Board. We want these youngsters coming in to go on and qualify before a Board, and we can pay a doctor now up to $11,000 a year. To get top salary, a doctor formerly had to go into an administrative position. Why should a good doctor have to be forced into an administrative position? It was operated on this theory: That if a manager of a hospital is paid $8,000, then a clinical director could only get $7,000 and then the chief of the surgical service could get only $6,000, and they had the positions scaled down that way until we actually got a chief of a medical service in our organization who was getting about $5200 a year. He was recommended for promotion for two or three years but couldn't get promoted because Civil Service wouldn't raise his position to the next grade. We

think it is perfectly stupid to grade a job when we are looking for men. We now hire a doctor for what we think he is worth and then we can always find a job for him.

These three requirements that I have told you about were what we thought was the first move before we could even start to improve this service. But we haven't yet done much for the patient. You know the Government organized slowly. We could write a good plan but it takes six months to find the people to operate the plan. You can't just go out and hire a doctor that is good. You don't find those people dropping around on your doorstep. You have got to go looking for people of the caliber you want. It has taken some time for us to look for people to plan and direct this enormous task. We haven't improved in many places yet, but I'll tell you about one of our hospitals. Before, it was understaffed, doctors working on a forty-four hour week like brick layers. When five o'clock in the afternoon came (I don't know whether a whistle blew, but everyone knew when it was five o'clock) practically all hands went home. There were 1700 patients in the hospital. After five o'clock in the afternoon there were two doctors on duty and one of those doctors operated a telephone switchboard. And if they worked overtime they got time and a half pay. It doesn't take very long, if you practice medicine like digging ditches, for the psychology of a doctor to become that of a ditch-digger.

That hospital today has fifty-three residents. If there are less than forty of these on duty any one night, someone will get fired. There are fully thirty certified attending staff men on half-time in that hospital. There are eighty-three people who are looking after patients who are not punching a time clock, and they are not getting overtime when they are called out at night. I get perfectly furious when I think of paying overtime to a doctor.

Another program about which nothing was ever done before the War — and by trial and error it was developed in the hospitals of the Army and Navy — is the rehabilitation program. We haven't done much in rehabilitation in this country. Medicine has left off care and treatment of patients far short of restoring them to full usefulness. Rehabilitation in the Veterans Administration is going to differ very widely from that in the Army. You have to remember that the Army and Navy get acute cases. We get largely the long term cases. We do get some acute cases, but these are not going to be much of our load. The need for rehabilitation in the Veterans Administration is going to be largely confined to the permanently disabled — vocational rehabilitation rather than physical rehabilitation — the training of these people to be able to live somewhat near a normal life with a severe disability. The paraplegic who will never be able to walk without a lot of assistance in appliances, the blind, the deaf, — all need vocational rehabilitation. The tuberculous cases, for instance. Up until this time we have kept such cases in hospitals until they could leave. Well, suppose that man came from a steel mill or was a stone cutter. How much have we trained him to see whether under working conditions he is going to stand up and stay well? We have got to rehabilitate many of these tuberculous cases because they should not be allowed to go back to the industry from which they came.

Why should a man who is disabled in his mind be deprived from earning something of a living? Many very frankly insane people can do useful and productive work if you make the shop conditions proper for them. I have seen them do it. Why shouldn't they work? Why shouldn't they be paid for it? So we have got first to develop colonies where the disabled can live. Many of these boys are married. They can't go out and live at home because they just don't have the facilities at home for taking care of them. Why don't we build colonies with cottages and workshops where they live, work and earn?

Now there is just one other thing to tell you — something that you are interested in — the out-patient program. I want to say I approved thoroughly in principle, and I haven't studied it in detail, the resolution passed by your House of Delegates. We have no set fee schedule that we have tried to force on any hospital or community. We are giving and taking. If you want a rotating staff, and it won't interfere with residency training, it won't make any difference to us so long as there is enough overlap that patient care doesn't suffer. We are only interested in giving the patients the best possible care. We will not quibble with you about how the job is done. You are going to do the job. Why should we dictate how you should do it? We are only going to tell you that we want the best medical care in the United States, and we know you can give it here in Providence.

There is a good deal of misunderstanding of the law governing out-patient care. The law is, of course, that only veterans with service-connected disabilities are entitled to out-patient care. We must have some screening process and some authorization for this treatment. We are not going to stand on this in cases of true and real emergency. In organizing and providing this out-patient care for patients, we are faced with this problem: Shall we deal with 125,000 physicians in this country and attempt to appoint each one of these individually and attempt to correlate their work, or shall we deal with organized bodies of physicians? The latter, of course, is the only logical approach to this problem. And if we deal with organized bodies, how large a body shall we deal with? The first plan

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was in Monmouth County in New Jersey. It was later found to be perfectly feasible to deal with States, even with states that vary as widely in rural and urban conditions as the State of Michigan, with the great city of Detroit and a large rural area. In the State of California, with Los Angeles and with San Francisco, and with rural areas, the physicians said we can have a plan that will take in the whole state. That means that there are only 49 states that we have to deal with rather than 3,020 counties.

There are several different obstacles. Prior authorization of treatment means we have got to set up administrative machinery that will give this authorization twenty-four hours a day, seven days a week. It is a curious thing that in the last twenty-five years the Veteran is the only person in the country that never got sick except between eight in the morning and five in the afternoon. We have got to change that.

Albert Deutsch, in his perfectly blistering article in *PM* about leadership in the American Legion, approved the entire medical program but with reservations on the out-patient program. He realizes that it is the only thing that can be done now, but he still reserves the right to criticize it except as an emergency measure. If this plan fails, it is going to be our fault or it is going to be your fault. What I think he was thinking about when he wrote that was the great amount of racketeering that grew up under the old regime in the Veterans Administration twenty-five years ago. It was an unholy scandal.

Now we must, as medical people, keep this out-patient program like Caesar's wife. We can't let any suspicion of honesty and integrity and fair dealing with either the veteran or the Government enter into this. We have got to do this, *or else*.

There are two types of arrangements that we made with state medical associations for out-patient care. We naturally prefer prepayment medical service because we buy it in bulk. We don't pay for insurance. We only pay the same schedule of fees that they charge their insured people. We are buying medical service from an insurance organization that is set up to provide medical service for their policy holders.

This problem is entirely too big for me alone. It is too big for the entire Veterans Administration alone. It is too big for the Federal Government alone. Every citizen must feel his responsibility in this veterans problem, and he must help if we are going to have any success in solving it.

Now in so far as medical care is concerned, I am going to give the veteran the best medical care without regard for anything else. The medical profession must support a satisfactory program of medical care for the veteran or it is "or else" for the medical profession, and that is not a threat. That is just talking between us doctors. If the medical profession doesn't solve this social problem you may as well just add socialized medicine underneath your shingles. But if we solve this problem and show this country that, as a free uncontrolled profession we can solve this popular problem, I think we might escape the disaster of socialization. But you can just put it right down that if this problem falls through, we will all be working for the Government. Now in turn I pledge myself not to abondon the veteran for any selfish interest of any sort or of any kind, nor will I betray the medical profession in any attempt to built a medical empire.

RESOLUTION REGARDING THE ORGANIZATION OF THE STAFF OF THE PROPOSED VETERANS HOSPITAL TO BE CONSTRUCTED IN PROVIDENCE

WHEREAS in Major General Hawley's address to the House of Delegates of the American Medical Association, delivered on December 3, 1945, he stated that it is the intention of the Veterans Administration to depend in great measure on the local organized medical profession for furnishing professional personnel to constitute a large part of the staffs of Veterans Hospitals, and,

WHEREAS according to his plans practicing physicians, surgeons and other specialists will, it is understood, be appointed to serve on the staff of each of these hospitals that is located in a large center of population just as they are appointed to serve on the staffs of civilian community hospitals, and,

WHEREAS in these hospitals desirable residencies and internships will, he said, be established and teaching functions will be developed,

THEREFORE be it now resolved that the Rhode Island Medical Society hereby heartily endorses the forward-looking policy outlined by General Hawley and expresses its desire to cooperate with the Veterans Administration in the operation of the hospital to be established in Providence. In addition, the following plan based on information published by the Veterans Administration (J. A. M. A. Vol. 20, No. 16, p. 1100) is presented by the Rhode Island Medical Society in the hope that it may be acceptable in whole or in part to the Veterans Administration and that it may be a means of attaining General Hawley's expressed objective, "The best in American Medicine for the Veteran":

In view of the fact that no medical school exists in Rhode Island it is suggested that the Rhode Island Medical Society be constituted the authority to deal with the Veterans Administration in the matter of nominating physicians to act as *senior consultants, consultants* and *ward officers* according to the published plan. It is also suggested that the consultants (who, it is understood, act in the capacity of attending or visiting physicians) be appointed to serve not less than three nor more than six months in each year so that they may still be able to hold positions in civilian hospitals and that their appointment to the staff of the Veterans Hospital will not result in depleting the staffs of the civilian hospitals of the state.

It is suggested that the Rhode Island Medical Society remain the authority which can nominate practicing physicians as they are needed to fill vacancies in the staff of the Veterans Hospital both in its out-patient and in-patient departments.

. . . . Adopted by the House of Delegates of the Rhode Island Medical Society, Jan. 31, 1946.

The RHODE ISLAND MEDICAL JOURNAL

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THE VOLUNTARY SURGICAL INSURANCE PLAN

The announcement within the past month that a prepaid voluntary surgical insurance program would be offered in the immediate future by the Hospital Service Corporation (Blue Cross) in cooperation with the Rhode Island Medical Society marked another progressive step in community planning for health care in Rhode Island for persons in the lower income groups. It also marked the culmination of a year of intensive study and research of the problem by a committee of physicians and laymen.

But the announcement of the proposal, and the preliminary steps already taken are but the beginning of a major task ahead. True, all the difficult initial hurdles have been taken in the complicated process of organizing the plan, mainly as the result of excellent cooperation between the Society and the Blue Cross, but the success of the entire program is in the hands of the physicians of Rhode Island. Their complete support, coupled with the tested experience of Blue Cross in merchandising and administering hospitalization insurance, should be an adequate challenge a year hence to those who favor the compulsory method over the voluntary way.

There are several phases of the proposed surgical plan that warrant emphasis. It will be a non-profit plan. It will operate under a single corporation (Hospital Service Corporation) with one board of directors of which one of every four will be a physician elected by the Rhode Island Medical Society, and with one executive director for both the hospitalization and the surgical services, thus making for lower administrative costs, and for better merchandising of the contract to be offered as a rider to the hospitalization agreement.

All income from the sale of surgical insurance contracts will be maintained in a separate fund from which participating physicians will be paid in accordance with a fee table established by the Rhode Island Medical Society and subject to amendment only by it. Participating physicians will contract with the Service Corporation to be eligible to serve under the program, and they must agree to underwrite the plan to the extent of accepting a proration of fees should such action be necessary to maintain the solvency of the surgical fund.

Present progress indicates that the enrollment of participating physicians looms as the major task ahead. The Society has already named its seven representatives who have been elected to the Board of directors of the Blue Cross. The Society has filed its affidavit with the Secretary of State to authorize Blue Cross to be the medical service corporation. Amendments have been adopted by

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the Blue Cross to its by-laws to guarantee a permanent medical representation on its board of directors and to leave the fee table entirely and forever in the hands of the medical profession. Meeting in special sessions the House of Delegates has drafted a fee table for the surgical procedures to be covered that is most favorable to the low income groups for whom the program is planned.

In assuming the task of operating the surgical insurance program Blue Cross, from a deep sense of public duty and because of a justifiable pride in its achievement in the field of hospitalization, pledges all its resources for the success of the plan. The physicians of Rhode Island have an even large stake in making the new venture successful, for back of them are the long years of effort to give steadily improving service to the public, and especially those persons in the lower income groups, coupled the conviction that any general medical plan tempered with compulsion respecting either the physician or the patient will certainly result in a very disasterous lowering of the level of medical care in this State and Nation.

THE CARE OF VETERANS — A CHALLENGE

The frank and forceful remarks of Major General Paul R. Hawley at the joint meeting of the Rhode Island and Providence societies on February fourth have not only persuaded the physicians of this state that he is quite in earnest in his determination to obtain "the best in American medicine for the Veteran" but also that, as a means to this end, he will cooperate with the organized profession in any reasonable plan that it wishes to propose. Specifically he is willing to contract for the urgent and immediate job of outpatient care and examination of veterans with the medical society itself, the surgical insurance organization or any other responsible agency which can represent the profession and act as its agent. In addition he is willing to make the medical society the authority in the state, in place of the "Dean's Committees" in communities where medical schools exist, responsible for the nomination of practicing physicians to serve on the staff of the new Veterans' Hospital which is to be erected in Providence. In this he recognizes that Providence, though without a medical school, is a real medical center and that the profession of the state is capable of carrying on in Providence the functions of a teaching hospital of the highest grade. In this matter General Hawley has definitely agreed to the plan proposed in the resolution passed by the House of Delegates (see page). This plan, which places the full responsibility in the hands of the organized profession represents a challenge which we should be eager to accept and it well may serve as a pattern to be used throughout the nation in establishment of Veterans' Hospitals in communities similar to ours.

THE NP VETERAN PROBLEM

Dr. Durfee's report in this issue is indeed a laudable effort and may well serve as an index of what might be expected from the neuropsychiatric problem amongst the veterans of World War II. However, it cannot be considered conclusive at this time since it is based upon observations from only 149 doctors of the total 600, and is the result of observations on only 2000 veterans, whereas the eventual veteran total will be about 90,000. This 20% observer ratio and 2.2% patient ratio has, however, revealed, as Dr. Durfee points out, that the neuropsychiatric problem appears to be one, which, for the most part, can be handled quite adequately by the private practitioner—this because 95% of the cases apparently were not considered serious neuropsychiatric casualties. If future events prove such a tentative conclusion to be a fact, it will relieve the burden which might unnecessarily be placed upon the specialized neuropsychiathic clinics, and so permit the latter to concentrate on the more serious problems.

The report also crystalizes the importance of the family doctor in restoring the veteran's confidence in himself, and in his ability to regain and improve his position in the community. It no doubt will serve to stimulate the formation of refresher courses, conducted by our able neuropsychiatric specialists to acquaint the private practitioner with the newer trends in neuropsychiatric patient management.

It may be well to note here that the Medical Society's representatives have attempted to keep pace with the expanding "NP veteran problem" by aiding in the establishment of neuropsychiatric clinics for the veterans, and that the local press has presented the problem without the undo emphasis which has appeared in other sections of the country.

MILITARY ANNOUNCEMENTS

TRANSFERS:

Lt. Col. Eric P. Stone, MC, Chief, Urological Service, Asheville General Hospital, White Sulphur Springs, West Virginia

Lt. Comdr. John R. Cranor, Jr., MC, USNR, U. S. Naval Air Station, Quonset Point, R. I.

PATRONIZE

JOURNAL

ADVERTISERS

OPINION POLL OF PHYSICIANS REGARDING NEUROPSYCHIATRIC CONDITIONS AMONG WORLD WAR II VETERANS IN RHODE ISLAND*

HILDEGARD DURFEE, PH.D.

The Author. *Hildegard Durfee, Ph.D., of Wakefield, R. I. Field Representative of the Neuropsychiatric Service, U. S. Veterans Administration.*

THE Veterans Administration is deeply concerned to expand and improve its medical services for veterans suffering from nervous or emotional conditions who do not need hospitalization but who could be benefited by the care of a private physician or outpatient clinic.

Considerable attention has been focused by the press, radio and screen on the veteran returning with war-shattered nerves. In some instances the so-called "NP veteran problem" has been so overemphasized as actually to create a problem. Many opinions have been expressed and estimates given but few facts are known on the local level.

In an effort to determine the incidence of neuropsychiatric conditions among World War II veterans, and the adequacy of the resources available to treat them, the Veterans Administration is conducting a field study in certain representative areas, of which Rhode Island was selected as one.

It was felt that the opinion of the medical profession on this question was of prime importance. The cooperation of the Rhode Island Medical Society was therefore enlisted and a questionaire sent out to all members during the early part of December, 1945. This report is a summary of the findings.

In all, 149 replies were received to the 600 questionaires sent; or about 25%, which may be considered a better than average return, especially from a group as overburdened as physicians. Of these, 137 questionaires lent themselves to tabulation, while comments and suggestions on the total number were noted and included in this analysis.

Some 2,000 veterans were seen by the 137 doctors reporting. Of these 24.6% were, in the opinion of the doctors, "definitely nervous or emotionally upset." In only 6.5% of the cases seen, however, was the nervous condition, in their opinion, so severe as "seriously to interfere either with their work, family life or social relations." In fact, of the veterans considered noticeably nervous 62% were reported employed and 13% self-employed; or a total of 75%. The employment status of the remaining 25% was in many instances unknown; but even assuming that the entire 25% were not gainfully employed, such unemployment may have been due also to factors other than their nervous condition.

It is felt that these findings should not be considered conclusive; they should be weighted as an opinion poll, not as statistical evidence. The number of veterans reported on in most cases is an estimate, not an actual count on the basis of records. The word "veteran" was in some instances interpreted to mean both servicemen and discharged veterans. There was undoubtedly some duplication of cases. It may also be assumed that there was considerable divergence of individual interpretation as to what constitutes "definitely nervous" or "serious interference" with work, family and social life; the nature of the nervous condition being in some instances perhaps not recognized in terms of psychiatric diagnosis. Fur-

continued on next page

DEPARTMENT OF MEDICINE AND SURGERY

VETERANS ADMINISTRATION

WASHINGTON 25, D. C.

January 28, 1946

Dear Dr. Kenney:

I want to express my appreciation to yourself and the members of the Rhode Island Medical Society for their cooperation on the study being conducted by this office of the incidence and nature of neuropsychiatric conditions among World War II Veterans.

In all, 149 replies were received to the questionnaires sent out to the members of your society. Many of them contained most helpful and pertinent observations and comments. A tabulation of the findings is under way and will be made available to you.

The Veterans Administration is anxious to work through the medical profession in every way possible. It is only through assistance such as yours, that we shall be able to give to the veteran the quality of medical service which he deserves.

Sincerely,

DANIEL BLAIN, M.D., *Acting Director*
Neuropsychiatric Service

*Published with the permission of the Acting Chief Medical Director, Department of Medicine and Surgery, U. S. Veterans Administration, who assumes no responsibility for the opinions expressed or the conclusions drawn by the author.

thermore, consideration must be given as to how representative the sampling is, both as to doctors reporting and veterans reported on. A proportion of the veterans seen were undoubtedly referred by the Veterans Administration for examination or treatment by fee-basis physicians, and may therefore constitute a special group.

What is significant is the *general impression* of the physicians that the per cent of veterans with serious nervous conditions is comparatively low. The implication is, in fact, that the doctors felt it is lower than might be expected, as is evidenced by their repeated (unrequested) insertion of the word "only" before the figures reported. Thus: "Only 1" . . . "Can remember *only* 2" . . . etc.

Supporting this view are the comments of three physicians, each of whom reported seeing a considerable number of veterans.

"As an eye specialist, I would expect to see such cases as eye symptoms, headaches, etc. fairly common in (veterans). I have, however, seen very few with marked symptoms, and from my experiences alone would say there is less of an NP condition among returned soldiers than in the rest of my practice."

"I have had occasion to talk with a great many of the veterans whom we have been X-raying for pension purposes. My impressions are that undoubtedly there are those among them who are in need of psychiatric care but their numbers are limited and the overwhelming majority impressed me as being absolutely normal."

"My experience with veterans has been chiefly in the course of my work at———College. Of this group only one had any domestic trouble because of emotional upset and maladjustment. The rest are just plain glad to get back to college. The office of the recorder of grades makes the important announcement that with a very few exceptions the former students who have been in the service and who have come back to finish their course are making grades 20% or more better than they formerly made. In some cases D students have turned into A's. . . . In general, the ex-service men I have seen do not feel that they are a problem in any way and don't want any special privileges or attention."

In answer to the question as to which resources the physicians referred cases they considered in need of psychiatric help, the following was reported:

28 doctors referred cases to a private psychiatrist
10 " " " " a mental hospital.
10 " " " " an outpatient mental hygiene clinic
5 " " " " a social agency
1 " " " " other doctors

Quite a few noted that they treated the cases themselves.

The number of doctors who indicated that they would like to know more about the neuropsychiatric outpatient services offered by the following agencies or clinics in Rhode Island, is given below:

53 doctors: Veterans Administration, Providence Regional Office
49 doctors: State Vocational Rehabitation Division
50 doctors: Neuropsychiatric Outpatient Clinic of Charles V. Chapin Hospital
40 doctors: Butler Hospital Outpatient Service

Of great interest were the comments and suggestions expressed by the physicians relative to the medical care of the psychoneurotic veteran. A considerable number of doctors felt that the most effective way of dealing with veterans having nervous conditions is through the family physician. One physician who is himself a veteran stated that, "The family physician can do more good for these patients than the clinics, institutions or administrations." Several physicians stated, in effect, "When possible, I handle the case myself." One doctor stated: "As I did some work in the Veterans Administration I believe these cases should go to a private psychiatrist or M. D." Another doctor stressed the importance of "Prompt care and supervision by Veterans Administration-family doctor cooperation." Two others commented: "As many veterans as possible should be advised to continue treatment with their own physicians, except in the very definitely psychotic veterans." "Personally I feel that as a private physician, it is possible to do more for these boys in many cases because they all have a fear of being tossed around and I feel that we owe these boys our personal attention even if it means a small sacrifice of time and effort."

Several doctors felt that patients with nervous disorders could not be treated successfully in clinics but should have the care of a private physician. They were apparently under the impression that outpatient clinics were "charity" clinics where veterans would not get the personal attention they needed. A typical quotation: "A veteran should not be treated as a charity case and referred to OPD Clinics, etc. He should get the best and I firmly believe he is getting shoved around by the Veterans Administration." Another comment: "In planning for veterans' psychiatric care this low level approach must be avoided. I don't see how any physician can do a proper job on a mass production schedule. . . . My feeling is that proper psychiatric care cannot be given in the ordinary clinic fashion. In setting up facilities for the veteran this thought must be kept in mind. It matters not whether the work is done at the Veterans Bureau, Chapin or Butler Hospital; what matters is the standard of care set up. I feel the sights set thus far have been low."

Several doctors remarked that what ex-soldiers need is not clinic or medical treatment, but rather understanding and sympathy within their own family. Several stressed the importance of "suitable occupations."

Some doctors recognized the value of the modern outpatient clinic. "I believe the Veterans Administration with a special NP clinic to care for those veterans who have returned and are suffering from neuropschiatric disabilities, is of great importance," one remarked. Another expressed himself at length on the quality of outpatient treatment that should be given. "Experience has shown us that the veteran who has a problem has a great need of talking to someone who will listen to him patiently, uninterruptedly and understandingly, and who will study his total situation—the psychological factors, the home situation, his work problems. In order to render the service to the veteran that is needed, the objective must be to establish outpatient clinics in which not only the psychiatrist but the psychologist and the social worker will function as a well-equipped team to give thorough examination, adequate individual treatment, and if necessary, prolonged treatment. Many of the veterans in need of such treatment have already been in numerous clinics and hospitals, and can themselves differentiate between what is adequate treatment and the too common brush-off with a pat on the back or a pill or both."

Several doctors felt that the burden of treating psychoneurotic veterans must be borne by the general practitioner who should be given psychiatric insights. "I don't think there will be enough psychiatrists to go around but maybe psychiatrists can start an educational program for physicians." A psychiatrist commented: "I hope very much that the general practitioner may early recognize symptoms of nervous disorders such as the long insomnia, increased irritability, extreme jumpiness, suspicion and seclusiveness, and refer such veterans to the psychiatrists in private practice or one of the NP outpatient clinics."

Three needs for more information and psychiatric orientation were expressed by the physicians or revealed in their comments: (1) specific information regarding the neuropsychiatric outpatient services at present available to veterans in R. I. (location, types of services, hours, eligibility, fees, etc.); (2) more knowledge of the nature of outpatient treatment as offered by the best clinics today, compared to that given by the mass-production clinic of old; and (3) deeper understanding and early recognition of neuropsychiatric disorders, to the end that the general practitioner may more effectively treat the milder cases himself, and refer the more serious conditions at an early stage for psychiatric attention.

The first need the R. I. Medical Journal met by publishing in its January, 1946, issue, a list of neuropsychiatric outpatient services available to veterans in R. I. As to the other two points, it may be pertinent to quote from the report of the Hershey Conference on Psychiatric Rehabilitation held last year. In response to the question "Who will treat the psychoneurotic veteran?" a committee appointed by the Conference formulated the following:

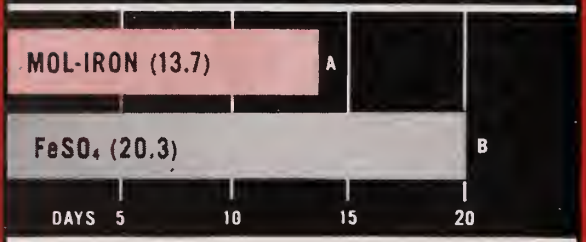
"We are convinced that the veteran is going to be treated by the general medical group of America. In hamlets, in the small towns, and in the metropolitan areas the veteran is going to go to the doctor he has known or to the doctor that is handy. . . . It is out belief that the general medical practictioner, wherever he is, ought to be able to handle the minor neuropsychiatric problems. We want to help him to do this effectively, and—especially important — to recognize those cases that he will not be able or should not attempt to treat. This involves training. . . . "

The question is, how can this training and orientation be provided and how can it be made to reach those men who live too far away or are too busy to take even a few days off to attend some special course? The recommendations of the committee in this regard are practical and thought-provoking. In view of the results of the questionaires submitted to the members of the R. I. Medical Society and the opinions and interest expressed by the doctors reporting, it is felt that these recommendations should merit serious consideration.



Dr. Herman C. Pitts, president-elect of the Rhode Island Medical Society, addresses the annual meeting of the directors and corporation of the Hospital Service Corporation. Seated (left to right) are Governor John O. Pastore, and Kenneth D. MacColl, president of the Blue Cross.

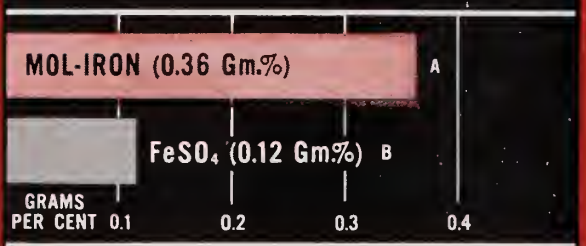
Rapidity of Clinical Response



(A) Completely effective therapeutic response (return to normal blood values) was obtained in on average of 13.7 days of Mol-Iron therapy.

(B) Ferrous sulfate therapy *failed* to produce normal hemoglobin values after an average of 20.3 days.

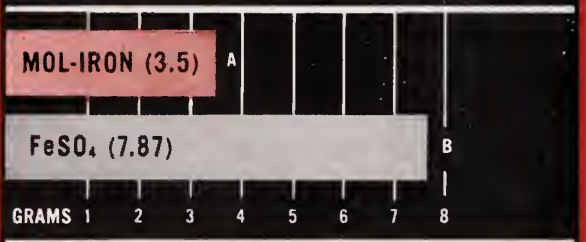
Average Daily Hemoglobin Increase



(A) The group treated with Mol-Iron averaged a daily hemoglobin increase of 2.48 per cent (0.36 Gm. per cent).

(B) The group treated with ferrous sulfate showed an average daily gain of hemoglobin of 0.83 per cent (0.12 Gm. per cent)—a response about one-third as effective.

Therapeutic Intake of Bivalent Iron



(A) The Mol-Iron treated group received an average total of 3.528 Gms. of bivalent iron to produce the sought for result (return to normal blood values).

(B) While an average ingestion of 7.871 Gms. of bivalent iron failed to achieve an optimal response in the ferrous sulfate treated group.

The charts summarize the results of a controlled study of comparative therapeutic response in post-hemorrhagic and nutritional hypochromic anemias.

The series includes 49 cases treated with Mol-Iron and 21 with exsiccated ferrous sulfate; the results are typical of those observed in treatment of iron-deficiency anemias with White's Mol-Iron.

A DEFINITE ADVANCE IN TREATMENT OF HYPOCHROMIC ANEMIA

White's MOL-IRON TABLETS

As compared with ferrous sulfate given i equivalent dosage—

1 Normal hemoglobin values are found to l restored more rapidly with White's Mo Iron. Daily rate of hemoglobin formatic may be *increased as much as 100% or mor*

2 Iron utilization is similarly more complet

3 Gastrointestinal tolerance is notably sati factory—even where other iron prepar tions have previously been poorly tolerate

INDICATIONS: Hypochromic (iron-deficienc anemias caused by inadequate dietary intal or impaired intestinal absorption of iron; e cessive utilization of iron, as in pregnancy ar lactation; chronic hemorrhage.

DOSAGE: One or two tablets three times dai after meals.

Available in bottles of 100 and 1000 tablets.

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NEW DEPARTMENT OF MEDICINE AND SURGERY in VETERANS ADMINISTRATION

THE signing, by President Truman, of H. R. 4717, a bill to establish a VA department of medicine and surgery, now sets up a new division under a chief medical director to replace the present Veterans Administration set-up under the Civil Service. The act aims to bring professional personnel into an organizations comparable with the Army and Navy Medical Corps and the U. S. Public Health Service.

Among the major provisions of the new act, besides setting up a medical department outside Civil Service, are the following:

(1) Specialists certified by VA will be paid 25 per cent more salary up to a ceiling limit of $11,000 a year.

(2) Residencies will be set up in VA hospitals where younger doctors may study to qualify as specialists. This will mean that veterans will be able to obtain the most up-to-date medical treatment — the same kind as if they were admitted to hospitals connected with the nation's leading medical schools and centers.

(3) Promotions will be made on recommendations of special VA boards which, in general, compare with the "selection boards" operating in the Army and Navy for higher ranking officers.

(4) Through the establishment of appointment, promotion and disciplinary boards, the legislation will permit VA to have complete supervision of its own professional employees, based upon their professional competence.

In order to overcome the acute personnel shortage, Major General Paul R. Hawley, Chief Medical Director under the new set-up, will need additional professional workers if he is to carry out his plans to give VA one of the most progressive medical programs in the nation.

The Administrator of Veterans Affairs, General Omar N. Bradley, will establish the regulations which will replace the Civil Service rules which formerly governed VA professional personnel. The program now coming into operation was first advocated by VA executives in 1922.

Both Generals Bradley and Hawley have advocated the change to a medical department as a means of obtaining the best doctors, dentists and nurses to treat veterans. They advocated extra pay for specialists, the establishment of residencies in VA hospitals, and the right of complete supervision over employment and separation of this class of VA employees on a basis of professional competence. The new act includes all three of these features.

The act approved by President Truman establishes the following divisions under the Chief Medical Director:

(1) Office of Chief Medical Director. The director will be paid a salary of $12,000 a year. A Deputy Medical Director will receive $11,500 and Assistant Medical Directors—not to exceed eight in number—will be paid $11,000 each.

(2) Medical Service.

(3) Dental Service.

(4) Nursing Service. The Director of Nursing Service will receive $8,000 annually and a Deputy Director, $7,000.

(5) Auxiliary Service. A chief pharmacist, chief dietitian, chief physical therapist, and a chief occupational therapist in the Auxiliary Service will be paid $6,000 annually. While the heads of the technical groups are appointed by the Administrator outside of Civil Service, the technicians working under them will continue to be chosen through existing Civil Service regulations. The act provides that the salary range for hospital attendants shall be $1,572 minimum to $1,902 maximum. The former pay scale provided for two grades at approximately these same salaries.

Appointments of key executives will be for a four year term, subject to removal by the Administrator for cause. Re-appointment will be for the same term.

Doctors, dentists, nurses and technicians now employed by the VA will be continued on their present jobs pending determination of their qualifications for appointment in the new medical department.

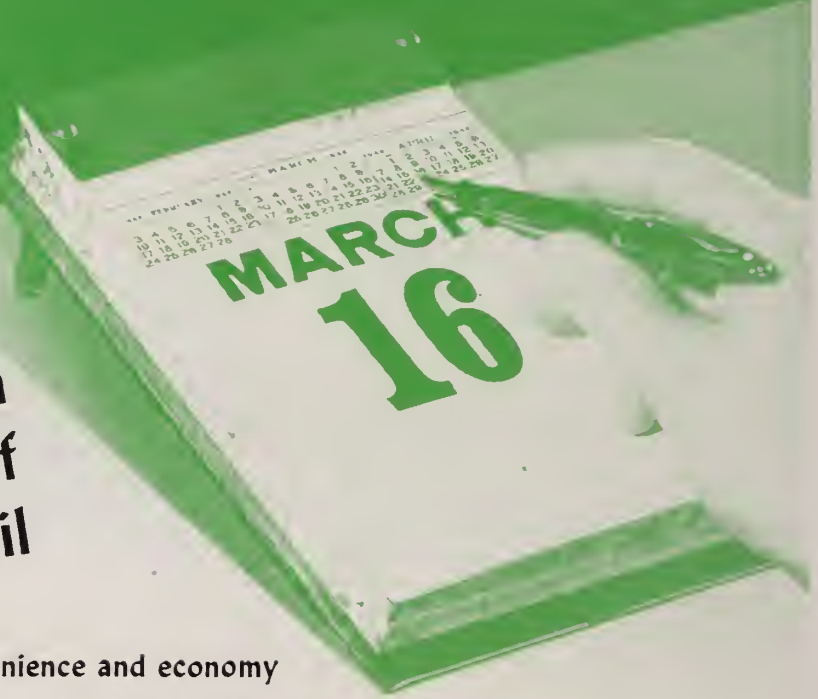
Another provision of the act which will permit professional improvement of VA medical personnel will allow up to five per cent of such employees to study or do research work for periods of time up to 90 days. This will enable doctors, dentists, nurses and technicians to attend recognized schools or work with the U. S. Public Health Service or other research groups. Officials pointed out that this would enable workers to keep abreast with the very latest developments in their respective fields.

The grades and annual full-pay ranges of the positions established by the new legislation are as follows:

MEDICAL SERVICE

Chief grade, $8,750 minimum to $9,800 maximum
Senior grade, $7,175 minimum to $8,225 maximum
Intermediate grade, $6,230 minimum to $7,070 maximum
Full grade, $5,180 minimum to $6,020 maximum
Associate grade, $4,300 minimum to $5,180 maximum
Junior grade, $3,640 minimum to $4,300 maximum

give him his next capsule on the 16th of April



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Supplied in packages of 6 capsules — sufficient dosage for 6 months. Available at prescription pharmacies.

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R. I. BLUE CROSS LEADS THE WAY*

C. RUFUS OREM, PH.D., C.P.A.
Director, Hospital Service Plan Commission of the American Hospital Association

RHODE ISLAND is the first state to enroll 50 per cent of its entire population in its non-profit Blue Cross hospital service plan. The Blue Cross Commission and the other 85 Plans in the United States and Canada have prepared a special Award of Merit certificate to symbolize our appreciation of your achievement.

The people of this state have been able to recognize their opportunity — an opportunity made possible through the energy, enthusiasm and vision of employers, union officials, hospital authorities, government spokesmen, working people, housewives, doctors, newspapermen, farmers — and, last but not least — executives, directors and board members of the Blue Cross itself.


BLUE CROSS
Award of Merit
TO
HOSPITAL SERVICE CORPORATION OF RHODE ISLAND
The Board of Trustees and the Blue Cross Plan Commission of the American Hospital Association, recognizing the signal achievement of the Hospital Service Corporation of Rhode Island, which has enrolled more than FIFTY PER CENT of the population of the state under voluntary Blue Cross protection, hereby issues this Certificate and extends this Award of Merit for improvement of the public health and welfare
AMERICAN HOSPITAL ASSOCIATION
George Bugbee

Your Executive Director, Stanley H. Saunders, has earned the respect of the entire movement by guiding Rhode Island's Plan to the position it now holds.

In less than seven years, your enrollment has grown, doubled, and redoubled until there are 350,000 persons whose hospital bills are paid by Blue Cross in Rhode Island.

Your accomplishment was not made easy by natural conditions. Rhode Island industry is not primarily big business. You could not simply enroll employees and family members of a few large plants. Your population, although largely urban, is heterogeneous, and you have a large foreign-language population.

You experimented courageously when you accepted small percentages of employed groups to demonstrate the value of your product. Your direct enrollment campaign to reach the self-employed, unemployed and those working in small shops has brought Blue Cross to many people who are not eligible for present social security benefits. Your public relations program, including the use of paid advertising, has adapted modern educational methods to the current task.

Blue Cross has convincingly met the demand for a way to budget the cost of hospital expense and has stimulated development of a State surgical Plan to be offered through Blue Cross, which I am glad to hear is just around the corner.

From the national viewpoint, Rhode Island's accomplishment is another milestone on the road of Blue Cross progress. Five years ago, we were delighted when all Plans reached a total of 4 million members. Today, there are more than 20 million in the United States and Canada. That figure can double in two years if management, labor, Plan executives, hospital leaders and government co-operate in the endeavor.

Thirteen other states—headed by Delaware and Massachusetts — have enrolled more than 20 per cent of their population, and some of them also will soon exceed 50 per cent. There are now only five states without a Blue Cross Plan. More than half the Plans now co-ordinate their hospital service with a surgical or medical service Plan or both, and

continued on page 211

*An address delivered before the Corporation and the Board of Directors of the Hospital Service Corporation of Rhode Island, at Providence, February 20, 1946.

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Sedative and Hypnotic

OUTSTANDING CHARACTERISTICS: —

High safety factar
Moderate duratian of action
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Wherever a barbiturate is indicated, DOROLIX will be found ta possess all the desirable qualities af an efficient sedative and hypnotic.

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BLUE CROSS LEADS THE WAY

continued from page 209

enrollment for this supplementary service is growing rapidly.

Voluntary methods for meeting health care needs are a major factor in the lives of millions of Americans today. How far can voluntary health plans go toward a complete national health program? The answers are influenced by the manner and degree to which all community resources and economic forces are used to finance health service and by the vision and determination of the health professions and institutions to make their services widely available on a convenient and economic basis.

The Blue Cross and representatives of the voluntary movement offer this program for greater service to the American people:

(1) Availability of protection everywhere. This has been virtually accomplished. Addition of the small States now without Blue Cross, however, will make it possible for national firms to obtain coverage for all employees everywhere.

(2) Co-operation of Blue Cross, labor and management to include health benefits in wage agreements. Organized labor has been a strong force in the crusade for better health and more convenient access to facilities and service. Since health benefits are financed from the earnings of employed persons it is logical that wage agreements should make allowance for economic loss and expenditure caused by sickness and injury.

(3) Enrollment of self-employed persons in urban and rural areas. Through farm bureaus, granges, unions and co-operatives, Blue Cross is now reaching people in small farming communities. Through direct enrollment programs, the way is being opened for membership of individuals with no group affiliation.

(4) Co-ordination of Blue Cross Plans for transfers and out of town benefits, and with protection for medical and surgical service. Close affiliation is necessary. The public regards medical and hospital costs as part of a single transaction, and wants benefits from a single source.

(5) Payroll deduction privileges in health service protection for Federal government employees. The largest American employer—the United States government—does not yet grant its employees the same convenient method of payment used by private industry and local governments.

(6) Co-ordination of voluntary plans with tax supported programs of medical care. Provision by the government of complete medical care and hospitalization for indigent members of the population, aid in the construction of hospital and clinic facilities where such assistance is required, and grants-in-aid to State-approved voluntary programs to permit relatively small contributions by the workers and thus encourage widespread participation, are all potential government functions.

Blue Cross sponsors wish voluntary programs to be judged by their best records and their reasonable propects. Here in Rhode Island, you have done a remarkable job. Governor Pastore, himself, marks the mid-point in your progress. He may be said to symbolize government's co-operation with its people—doing something *with* them instead of *for* them. And as Blue Cross and other voluntary programs grow, you can take pride in your own accomplishments. You have led the way. You deserve sincere congratulations on your results.

And, now, on behalf of the Blue Cross Commission of the American Hospital Association, it gives me great pleasure to present the Blue Cross of Rhode Island with this special Award of Merit, testifying to your achievement in enrolling 50 per cent of the population of this State.

RHODE ISLAND HOSPITAL

PROVIDENCE 2, R. I.

February 6, 1946

Dear Doctor:

The shortage of hospital beds is of great concern to the people, the physicians and the Trustees of hospitals. All of the hospitals of Providence are exerting every effort to provide the necessary hospital care. However, this is not adequate. There just are not enough beds to meet every need. This community is, however, better off than many.

The only reasonable approach, as we see it, is to accept patients who need hospital care the most. The Rhode Island Hospital is committed to care for all emergencies in the community. The result is that not many beds are available to care for cases of choice.

It is wise to have the same general procedure govern our actions in all units of the Rhode Island Hospital if we are to provide the needed service for the most number in the community. Fortunately, the Potter Building and the Crawford Allen Memorial have capacity adequate for currently demonstrated needs.

The Trustees have requested the Administration to study ways and means of meeting the community need, until the building program can be consummated. Suggestions in writing from the Medical profession will be appreciated. Your understanding and help are essential to the success of our activity in behalf of the people we jointly serve.

Very truly yours,

OLIVER G. PRATT, *Executive Director*



"It's only a cold, doctor..."

"But it sure would be nice to breathe again!" The patient's a little apologetic for calling you in on just a cold—but fearful that it might turn into "something serious".

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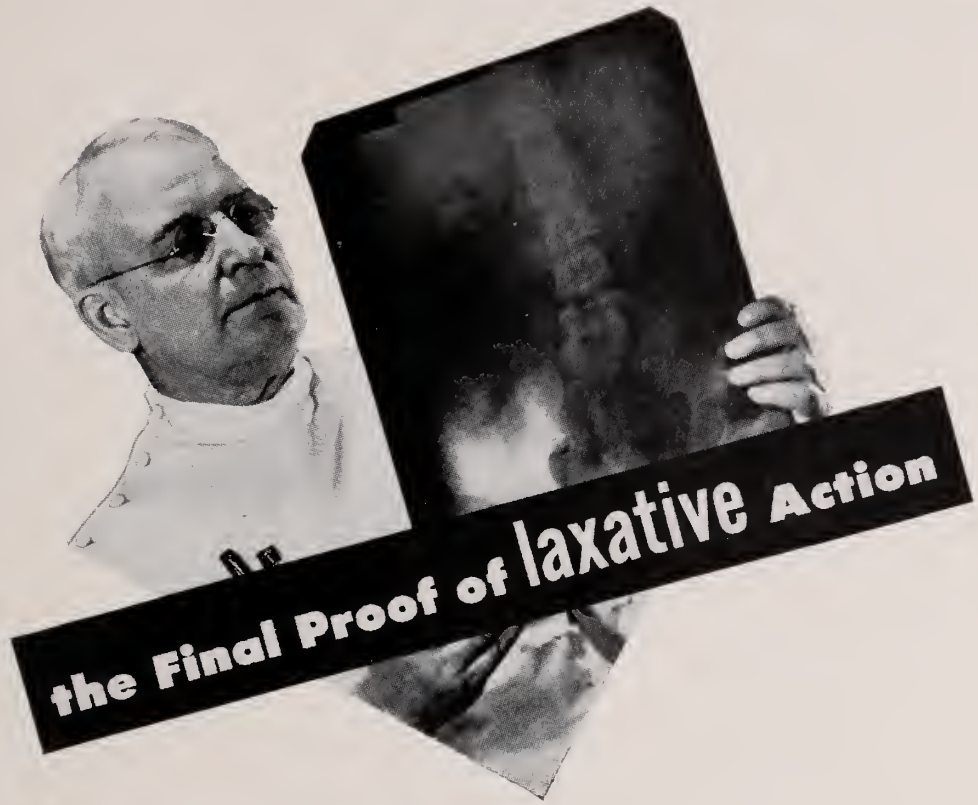
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DOSAGE: *Adults:* 3 tablets with water at bedtime. *Older children:* 1 or 2 tablets. Caution—any laxative is contraindicated if symptoms of appendicitis or intestinal obstruction are present.

HOW SUPPLIED: Bottles of 50 tablets.

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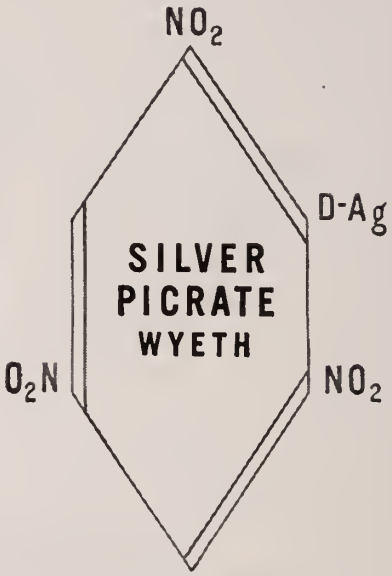
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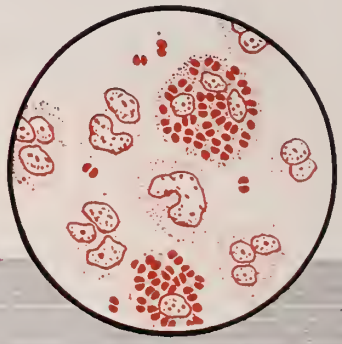
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NATIONAL HEALTH PROGRAM OF THE A M A*

THE Board of Trustees of the American Medical Association and the Council on Medical Service of the American Medical Association at a meeting just completed in Chicago have taken a long step toward protection of the American people against the costs of sickness through participation in a voluntary prepayment sickness plan now developed under the authority of the American Medical Association.

The fundamental step in the development of this plan was the establishment of standards of acceptance for medical care plans which have the approval of the Council on Medical Service of the American Medical Association. Any plan which meets the standards of the Council will be entitled to display the seal of acceptance of the American Medical Association on its policies and on all of its announcements and promotional material. In order to qualify for acceptance, the prepayment plan must have the approval of the state or county medical society in the area in which it operates. The medical profession in the area must assume responsibility for the medical services included in the benefits. Plans must provide free choice of a qualified doctor of medicine and maintain the personal, confidential relationship between patient and physician. The plans must be organized and operated to provide the greatest possible benefits in medical care to the subscriber.

Medical care plans may be in terms of either cash indemnity or service units, with the understanding that benefits paid in cash are to be used to assist in paying the costs incurred for medical service. The standards also include provisions relative to the actuarial data that are required, systems of accounting, supervision by appropriate state authorities and periodic checking and reporting of the progress of the plan to the Council.

Coincidentally with the announcement of these standards of acceptance, there was organized, as a voluntary federation, an organization known as Associated Medical Care Plans, Inc. This independent association will include as members all plans that meet the minimum standard of the Council on Medical Service of the American Medical Association. The Associated Medical Care Plans will undertake to establish co-ordination and reciprocity among all of these plans so as to permit transference of subscribers from one plan to another and use of the benefits in any state in which a subscriber happens to be located. Under this method great industrial organizations with plants in various portions of the United States will be able to secure coverage for all of their employees. Moreover, it will be possible for the Veterans Administration, welfare and industrial groups as well as government agencies, to provide coverage for the people in any given area through a system of national enrollment. In addition, the Associated Medical Care Plans, Inc., will undertake research and the compilation of statistics on medical care, provide consultation and information services based on the records of existing plans and engage in a great campaign of public education as to the medical service plan movement under the auspices of state and county medical societies.

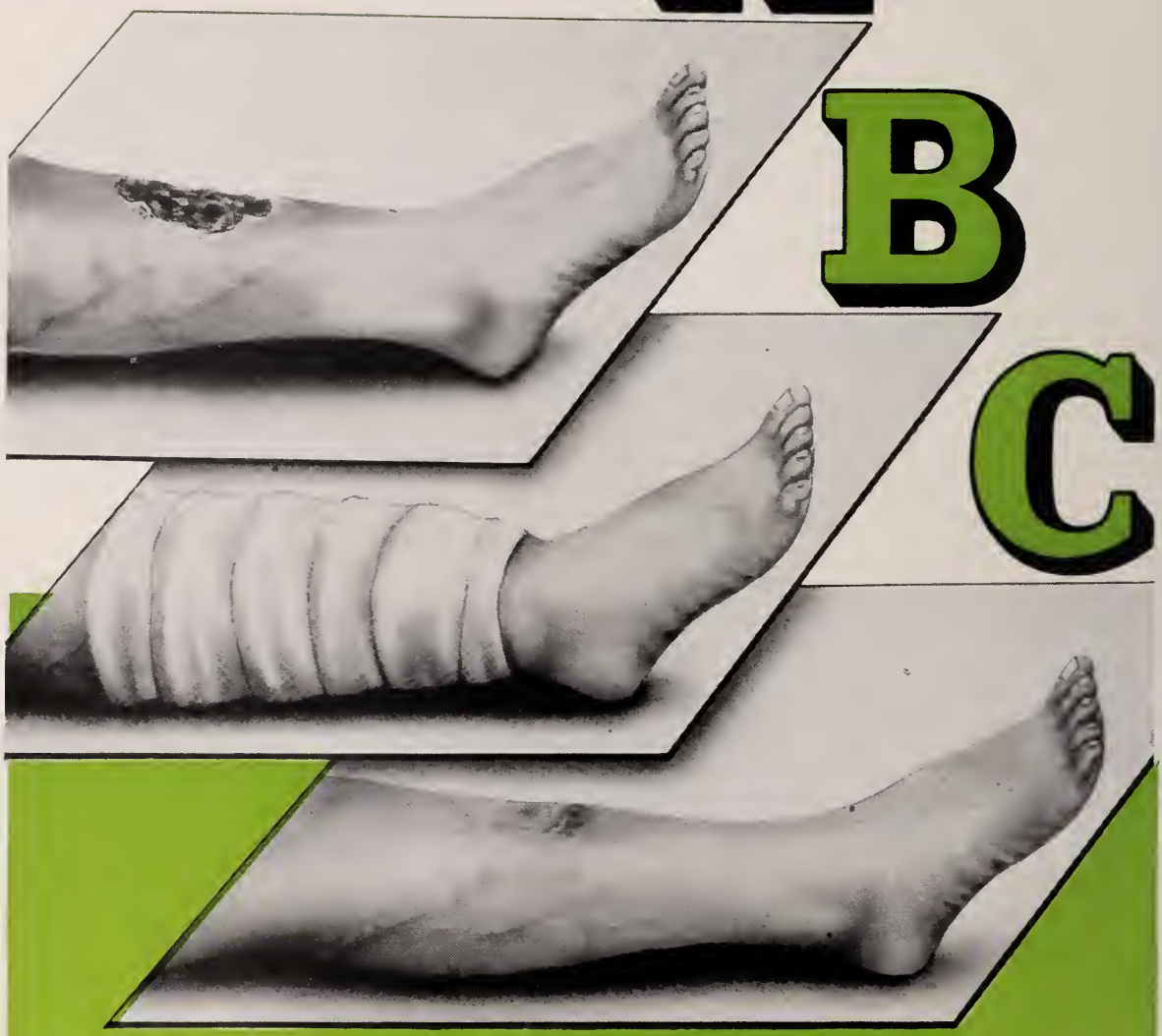
The Board of Trustees of the American Medical Association also announced the establishment under its Council on Medical Service of a Division of Prepayment Medical Care Plans with a director and a staff who will administer the activities of the Council on Medical Service related to the promotion and development of medical care plans in all of the states.

In announcing its proposals for a nation-wide provision of sickness insurance on a mutual nonprofit basis, the Association through its President and the Board of Trustees authorizes the publication of its complete health program with the ten points, which include the development of services in the field of preventive medicine, maternal and child health, voluntary prepayment plans for protection against the costs of sickness, compensation for loss of wages due to illness, the care of the veteran and the development of a high standard of housing, nutrition, clothing and recreation. The American Medical Association last June, through its Board of Trustees and Council on Medical Service, announced a 14-point program to improve the health and medical care situation in the United States. In October, 1945, the interpretation of these 14 points and methods of implementation were adopted by the Council on Medical Service. In December, 1945, the House of Delegates

continued on page 219

*As released to the press February 16, 1946 by the American Medical Asociation.

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of superficial indolent ulcers and other skin lesions with TYROTHRICIN . . . a most important antibiotic agent.

TYROTHRICIN

used in wet packs or by irrigation, is effective against streptococcic, staphylococcic and pneumococcic infections of superficial tissues, deeper tissues made accessible by surgical procedures, and body cavities in which there is no direct communication with the blood stream.

Be Sure

CORAMINE 5cc.

Is In Your Bag



BE SURE it's in *your* bag! Confidence in meeting the ever-present possibility of respiratory failure is assured when you know that you have the 5 cc. ampuls of Coramine with you. Prompt, powerful respiratory stimulation results from intravenous dosage of 5 cc. or more. Coramine's low toxicity, assuring a wide margin of safety, allows repetition of this dosage in cases where initial clinical response is not adequate.

CORAMINE—*Trade Mark Reg. U. S. Pat. Off.*

CIBA PHARMACEUTICAL PRODUCTS, INC.

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Steroid Hormones · Fine Pharmaceuticals

NATIONAL HEALTH PROGRAM OF AMA
continued from page 215

approved the whole program, suggested its rearrangement and directed the Board of Trustees to keep the program constantly up to date so that it will stay at least even with and, if possible, a step ahead of the needs of the public.

With this in mind the Board of Trustees has adopted a restatement of the 14-point program, which clarifies still further the position of the American Medical Association on some of these points and brings into the program more definitely such matters as maternal and child welfare, medical research, the medical care of the veteran, and the part to be played by the voluntary health agencies. This restatement follows:

National Health Program of the American Medical Association

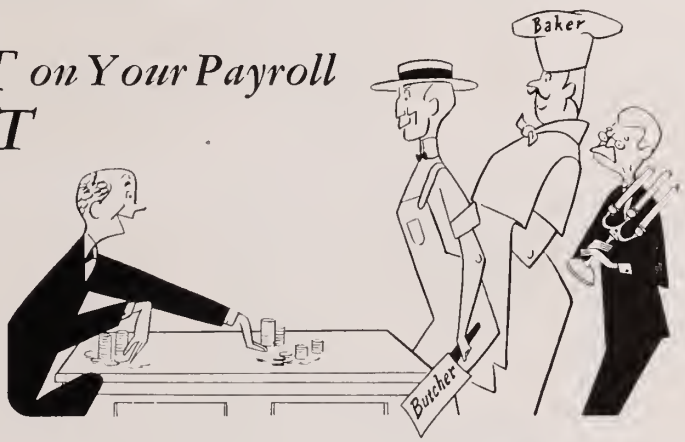
(1) The American Medical Association urges a minimum standard of nutrition, housing, clothing, and recreation as fundamental to good health and as an objective to be achieved in any suitable health program. The responsibility for attainment of this standard should be placed as far as possible on the individual, but the application of community effort, compatible with the maintenance of free enterprise, should be encouraged with governmental aid where needed.

(2) The provision of preventive medical services through professionally competent health departments with sufficient staff and equipment to meet community needs is recognized as essential in a health program. The principle of federal aid through provision of funds or personnel is recognized with the understanding that local areas shall control their own agencies as has been established in the field of education. Health departments should not assume the care of the stick as a function since administration of medical care under such auspices tends to a deterioration in the quality of the service rendered. Medical care to those unable to provide for themselves is best administered by local and private agencies with the aid of public funds when needed. This program for national health should include the administration of medical care including hospitalization to all those needing it but unable to pay, such medical care to be provided preferably by a physician of the patient's choice with funds provided by local agencies with the assistance of federal funds when necessary.

(3) The procedures established by modern medicine for advice to the prospective mother and for adequate care in childbirth should be made avail-

continued on page 221

Put Yourself **FIRST** *on Your Payroll instead of* **LAST**



How to Have Income for the Rest of Your Life

When you sit down to take care of your monthly bills, the butcher, the baker, the candlestick maker, each gets what's coming to him — but are you equally careful about setting aside something for yourself and your family?

Too many of us devote our income to meeting present and past expenses, and save only if there's something left over.

But why put yourself last on the list? Make a definite program for the future a regular part of your budget.

Read about The Connecticut Mutual's Retirement Income plan which enables you to enjoy real peace of mind. Let us send you a copy of our booklet, "What Is the Retirement Income Plan?"

The Connecticut Mutual Life Insurance Company
Walter K. R. Holm, Jr., *General Agent and Associates*
Suite 1814, Industrial Trust Building, Providence 3, Rhode Island



HOW OFTEN DO *you* USE X-RAYS IN ENT DIAGNOSIS?



Probably not as often as you would like to. You may unconsciously rule out x-ray confirmation because of delay and inconvenience to the patient who has to go out of your office for this service. This no longer need be the case. By installing a complete Ritter Treatment Room with a Ritter X-Ray, you can give your patients complete x-ray diagnosis without delay. Ask our representative for the new booklet, "Two Important Years," and read how to put this modern diagnostic tool, the Ritter X-Ray, to work for you in your own office.

ANESTHETIC GASES • PHYSICIANS', SURGEONS', MEDICAL AND HOSPITAL SUPPLIES

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HOSPITAL BEDS • WHEEL CHAIRS • TRUSSES • BELTS • SUPPORTS • SICK ROOM SUPPLIES

NATIONAL HEALTH PROGRAM OF AMA

continued from page 219

able to all at a price that they can afford to pay. When local funds are lacking for the care of those unable to pay, federal aid should be supplied with the funds administered through local or state agencies.

(4) The child should have throughout infancy proper attention including scientific nutrition, immunization against preventable disease, and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child care and infant welfare stations administered under local auspices with support by tax funds whenever the need can be shown.

(5) The provision of health and diagnostic centers and hospitals necessary to community needs is an essential of good medical care. Such facilities are preferably supplied by local agencies, including the community, church and trade agencies which have been responsible for the fine development of facilities for medical care in most American communities up to this time. Where such facilities are unavailable and cannot be supplied through local or state agencies, the federal government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established. (Hill-Burton bill)

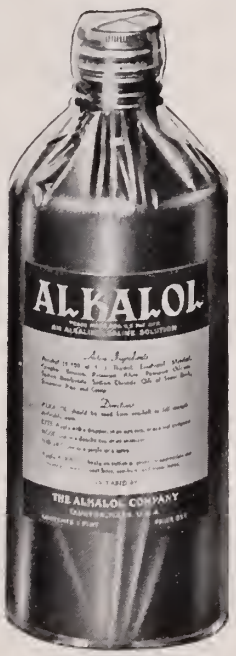
(6) A program for medical care within the American system of individual initiative and freedom of enterprise includes the establishment of voluntary nonprofit prepayment plans for the costs of hospitalization (such as the Blue Cross Plans) and voluntary nonprofit prepayment plans for medical care (such as those developed by many state and county medical societies). The principles of such insurance contracts should be acceptable to the Council on Medical Service of the American Medical Association and to the authoritative bodies of state medical associations. The evolution of voluntary prepayment insurance against the costs of sickness admits also the utilization of private sickness insurance plans which comply with state regulatory statutes and meet the standards of the Council on Medical Service of the American Medical Association.

(7) A program for national health should include the administration of medical care, including hospitalization, to all veterans, such medical care to be provided preferably by a physician of the veteran's choice with payment by the Veterans Administration through a plan mutually agreed on between the state medical association and the Veterans Administration.

(8) Research for the advancement of medical science is fundamental in any national health program. The inclusion of medical research in a National Science Foundation, such as proposed in pending federal legislation, is endorsed.

(9) The services rendered by volunteer philanthropic health agencies such as the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Inc., and by philanthropic agencies such as the Commonwealth Fund and the Rockefeller Foundation, and similar bodies have been of vast benefit to the American people and are a natural outgrowth of the system of free enterprise and democracy that prevail in the United States. Their participation in a national health program should be encouraged and the growth of such agencies when properly administered should be commended.

(10) Fundamental to the promotion of the public health and alleviation of illness are widespread education in the field of health and the widest possible dissemination of information regarding the prevention of disease and its treatment by authoritative agencies. Health education should be considered a necessary function of all departments of public health, medical associations, and school authorities.



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TAUNTON, MASS.

for topical Otologic chemotherapy



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offers these unique clinical advantages

POTENTIATED ANTIBACTERIAL POTENCY
urea-sulfanilamide mixture more effective than either drug used independently.[1] Not inhibited by pus.

BETTER TISSUE DIFFUSION
more active diffusion of sulfanilamide through living and dead tissues due to urea content.[2]

INCREASED PHYSIOLOGIC DEBRIDEMENT
local therapy with urea in chronic otitis media brings about "a more adequate removal of the gross and microscopic debris in the recesses of the middle ear."[3]

WIDE FIELD
effective in BOTH acute AND chronic otologic infections. Active against sulfonamide-resistant bacteria.[4]

WELL TOLERATED
freedom from alkalinity virtually obviates local irritation.

ANALGESIC
provides effective chlorobutanol analgesia without impaired sulfonamide activity.

White's Otomide presents a stable, non-irritating solution of sulfanilamide, urea and chlorobutanol in a glycerin vehicle of unusually high hygroscopic activity.

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Pharmaceutical Manufacturers · Newark 7, N. J.

AVAILABLE IN DROPPER BOTTLES OF ONE-HALF FLUID OUNCE (15 cc.) ON PRESCRIPTION ONLY

FORMULA

SULFANILAMIDE	5%
CARBAMIDE (urea)	10%
CHLOROBUTANOL	3%
GLYCERIN (high sp. gr.)	q. s.

1. *Tsuchiya, H. M., et al.: Proc. Soc. Exp. Biol. and Med., 50:262, 1942.*

2. *McClintock, L. A. and Goodale, R. H.: U. S. Naval Med. Bull., 41:1057, 1943.*

3. *Mertins, P. S. Jr.: Arch. Otolaryng., 26:509, 1937.*

4. *Strakosch, E. A. and Clark, W. G.: Minn. Med., 26:276, 1943.*

AMENDMENTS TO THE BY-LAWS

At the meeting of the Rhode Island Medical Society held on February 4, 1946 the following amendments to the By-Laws were adopted. (Changes made are noted in italics)

ARTICLE X

STANDING COMMITTEES AND BOARDS OF TRUSTEES

Section 1. NAMED. — The standing committees of the Society consist of the following:

(1) Committee on Scientific Work *and Annual Meeting*
(2) Committee on Public Laws
(3) Committee on Publication
(4) *Committee on Postgraduate Education*
(5) Committee on Medical Economics
(6) Committee on Industrial Health
(7) Committee on the Library
(8) *Committee on Public Policy and Relations*
(9) Trustees of the Rhode Island Medical Society Building
(10) Trustees of the Caleb Fiske Fund
(11) Trustees of Special Funds
(12) Auditors

Section 2. REQUIRED REPORTS. — Each of these Committees shall at the May meeting of the House of Delegates report in writing concerning its activities during the past year. The Trustees of the Caleb Fiske Fund and the Trustees of the Special Funds shall report to the Council.

Section 3. VACANCIES. — If an elected committeeman dies, resigns, is removed or fails, his successor shall be elected *in accordance with the procedure set forth for the election of members to the respective committees.*

Section 4. ELECTION OF MEMBERS. — *The Standing Committees on Scientific Work and Annual Meeting, Public Laws, Publication, Postgraduate Education, Medical Economics, Industrial Health, Public Policy and Relations, and the Library, shall each consist of the President and the Secretary, ex officio and nine (9) members elected by the House of Delegates.*

Section 8. POSTGRADUATE EDUCATION. — *The Committee on Postgraduate Education shall act in conjunction with the Council to provide postgraduate clinics, courses and other instruction for the component societies and the members of this Society.*

Section 12. PUBLIC POLICY AND RELATIONS. — *The Committee on Public Policy and Relations shall concern itself with all matters of public policy, public relations, education and information relative to medicine and public health.*

ARTICLE V. — OFFICERS

Section 11. TREASURER.— . . . . . ;(3) at the Council meeting *preceding the meeting of the House of Delegates in September* to present to the Council, for its approval, a budget of necessary expenses of the Society for the ensuing year and to pay all bills within the scope of the approved budget: . . . . ."

A Lifetime Investment in Enjoyment



Frederick B. Thurber
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Certified Gemologists

Tilden-Thurber
PROVIDENCE
Registered Jewelers, American Gem Society

Formulac



A NUTRITIONALLY ADEQUATE INFANT FOOD

FORMULAC is the trade-name for a new product—a reduced milk in liquid form—supplemented with sufficient vitamins and minerals to render it an adequate food for infants.

FORMULAC was developed by E. V. McCollum to fill a long-felt pediatric need for a milk containing sufficient vitamins and minerals to meet the nutritional requirements of a growing infant *without supplementary administration*. The McCollum method of incorporating vitamins into the milk itself eliminates the risk of maternal error or oversight.

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FORMULAC, supplemented by carbohydrates at your discretion, presents a flexible basis for formula preparation, readily adjustable to each individual child's needs.

FORMULAC has been tested clinically, and proved satisfactory in promoting infant growth and development. Priced within range of even low income groups, this inexpensive infant food is on sale at most drug and grocery stores.



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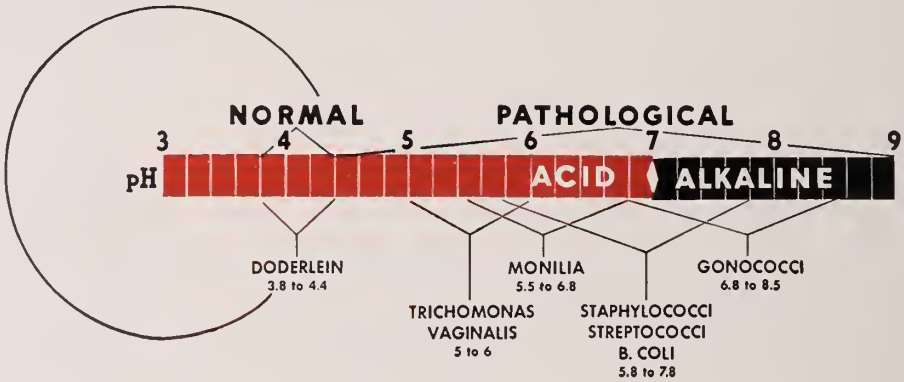
COMPONENT SOCIETIES BY MEDICAL DISTRICTS — 1946

Society	*Delegates*	*Councillor*	*Officers*	*Meeting*
Kent County Medical Society	Rocco Abbate	Fenwick Taggart	President, Whitman Merrill Vice President, P. Erinakes Secretary, J. E. Vidal Treasurer, John A. Mack	2nd Thursday of each month
Newport County Medical Society	James Callahan Samuel Adelson	Norman MacLeod	President, A. M. Tartaglino Vice Pres., W. A. Stoops 2nd Vice Pres., P. P. Ciarla Secretary, Harry Brownell Treasurer, N. U. Zielinski	4th Tuesday of every other month—Jan., Mar., May, July, Sept. and Nov.
Pawtucket Medical Association	Joseph L. Turner Walter J. Dufresne Earl J. Mara Stanley Sprague	James L. Wheaton	President, Wm. N. Kalcounos Vice Pres., J. F. Sullivan Secretary, M. E. J. Rohr Treasurer, L. A. Senseman	On or after 3rd Thurs. of each month at time and place designated by the Pres. (except July - August)
Washington County Medical Society	Linwood H. Johnson J. R. Tatum	John P. Jones	President, S. P. Turco Vice Pres., L. A. Morrone 2nd Vice Pres., S. A. Capalbo Sec'y & Treas., J. R. Tatum	2nd Wednesday Jan., Apr., July, October
Woonsocket Medical Society	Guyon G. Dupre	Victor H. Monti	President, H. L. Emidy Vice Pres., Joseph Reilly Secretary, P. E. Boucher Treasurer, Richard Dowling	2nd Tuesday, alternate months, Sept. - June
Providence Medical Association	Bertram H. Buxton H. G. Calder A. V. Migliaccio A. Henry Fox Arcadie Giura Alex M. Burgess Emery M. Porter Henry E. Utter George W. Davis Kalei K. Gregory Edward B. Famiglietti	Emery M. Porter	President, Paul C. Cook Vice Pres., Guy W. Wells Secretary, Frank Cutts Treasurer, Wm. P. Davis	1st Monday of each month; Oct. — May inclusive

Peter F. Harrington	Paul C. Cook	William Horan
Frank I. Matteo	Peter P. Chase	P. I. O'Rourke
E. Wade Bishop	J. L. Belliotti	Robert Baldridge
G. Edward Crane	Robert H. Whitmarsh	George Waterman
Arthur E. Martin	Frank Cutts	Herman A. Lawson
B. Earl Clarke	Wm. P. Davis	

Society	*Officers*	*Annual Meeting*	*Chairman, Standing Committees*
Rhode Island Medical Society	President, John F. Kenney Vice Pres., Joseph H. Ladd Pres. Elect., Herman C. Pitts Secretary, Wm. P. Buffum Treasurer, Charles J. Ashworth Ass't Sec'y, Morgan Cutts Ass't Treas., G. Raymond Fox	May 15 & 16, 1946 at Rhode Island Medical Society Library, 106 Francis Street Providence 3, R. I.	Russell R. Hunt & P. Batchelder, Auditors Charles Bradley, Com. on Arrangements James P. Deery, Com. on Industrial Health Herbert C. Partridge, Com. on Library Alex M. Burgess, Com. on Med. Economics Jesse P. Eddy, 3rd, Com. on Med. Education H. G. Calder, Com. on Publication Wm. H. Foley, Com. on Public Laws

Control the pH



In acute or chronic vaginitis, Floraquin restores the normal pH, destroys pathogenic organisms and promotes rehabilitation of the vaginal mucous membrane with respect to its glycogen content.

FLORAQUIN contains the nontoxic protozoacide, *Diodoquin*, together with lactose and dextrose. This product of Searle Research brings about the reestablishment and maintenance of the normal range of vaginal acidity (pH 3.8 to 4.4) unfavorable to vaginal infections.

FOR OFFICE INSUFFLATION—Floraquin Powder in bottles of 1 oz. and 8 oz.

FOR HOME ROUTINE—Floraquin Tablets in boxes of 24.

Floraquin is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois

SEARLE *Research in the Service of Medicine*

PRELIMINARY REPORT OF HEALTH DEPARTMENT STATISTICS

PROVIDENCE * RHODE ISLAND

1945

	1945	1944	1943
VITAL STATISTICS			
Deaths all	3158	3268	3575
Deaths under 1	227	275	354
Deaths over 70	1120	1241	1219
Births	8232	8192	8564
Marriages	2813	2619	2707
Infant Mortality	27.57	33.57	41.34
Death Rate	11.91	12.42	13.69
Birth Rate	31.06	31.14	32.81
PRINCIPAL CAUSES			
1. Heart Disease	1082	1057	1101
2. Cancer	446	451	493
3. Penumonia	115	174	186
4. Nephritis	188	198	235
5. Cerebral Hemorrhage	224	247	231
6. Auto Accidents	41	28	31
LABORATORY EXAMINATIONS			
Chas. V. Chapin Hospital	27888	27113	32846
MILK DEPARTMENT			
No. Samples Tested	22373	23621	20252
No. Licenses Issued	1329	1411	1429
PHYSICIANS			
No. Visits to Sick Poor	1788	2266	4160

	1945	1944	1943
DIPHTHERIA IMMUNIZATION			
No. Schick Tests	7048	7900	7391
No. Alum. Toxoid Treat.	4715	4199	4006
SMALLPOX IMMUNIZATION			
No. Vaccinated	2512	2871	2434
INSPECTORS			
Food Inspector:			
Inspections	8687	8133	8221
Licenses Renewed	1779	1650	1482
New Licenses	92	100	42
Transfers	131	103	61
Licenses Withdrawn	1	0	0
Licenses Not Approved	0	2	0
Licenses Revoked	1	3	3
Sanitary Division:			
No. of Visits	7524	6855	6451
Dog, Cat Bite Visits	1248	1270	1318
Kennel Lic. Approved	78	80	65
Garbage Lic. Approved	21	20	20
NURSING VISITS			
Communicable Diseases	4626	7114	10246
Child Hygiene	23591	25169	26161
Parochial Schools	3200	5010	4060
Tuberculosis—Home (DNA)	4958	4845	5964
CHILD HEALTH STATIONS			
Visits by Children	2599	3293	3945

COMMUNICABLE DISEASES

	CASES 1945		CASES 1944		*DEATHS* 1945		*DEATHS* 1944	
	Res.	*Non-Res.*	*Res.*	*Non-Res.*	*Res.*	*Non-Res.*	*Res.*	*Non-Res.*
Diphtheria	5	3	15	7	1	0	2	1
Scarlet Fever	256	60	263	86	0	0	1	1
Measles	106	0	3038	36	0	0	1	1
Whooping Cough	994	25	388	6	2	2	2	1
Pulmonary Tuberculosis	407		383		54	15	58	14
Septic Sore Throat	5	0	6	0	0	0	0	0
Streptococcus Sore Throat	26	1	61	2	0	1	1	1
Gastro Enteritis	65	25	58	28	5	6	19	13
Bacillary Dysentery	30	9	21	6	0	0	0	0
Poliomyelitis	0	4	6	8	0	0	0	2
Epidemic Meningitis	17	17	54	60	2	1	6	6
Typhoid Fever	3	2	5	3	0	0	1	0
Paratyphoid Fever	6	1	2	4	0	0	0	1
Epidemic Encephalitis	1	4	1	2	0	0	0	0
Ophthalmia Neonatorum	5	1	0	0	0	0	0	0
Undulant Fever	0	0	0	2	0	0	0	0
Infectious Mononucleosis	4	3	0	0	0	0	0	0
Trichinosis	2	0	0	2	0	0	0	0
Tetanus	0	0	2	3	0	0	0	0

Includes Non-Residents

MICHAEL J. NESTER, M.D.,
Superintendent of Health

AT HOME OR AWAY

SPOT TESTS

SIMPLIFY URINALYSIS

NO TEST TUBES • NO MEASURING • NO BOILING

Diabetics welcome "Spot Tests" (ready to use dry reagents), because of the ease and simplicity in using. No test tubes, no boiling, no measuring; just a little powder, a little urine—color reaction occurs at once if sugar or acetone is present.

Galatest
FOR DETECTION OF SUGAR IN THE URINE

Acetone Test (DENCO)
FOR DETECTION OF ACETONE IN THE URINE

THE SAME SIMPLE TECHNIQUE FOR BOTH

1. A LITTLE POWDER



2. A LITTLE URINE

COLOR REACTION IMMEDIATELY



A carrying case containing one vial of Acetone Test (Denco) and one vial of Galatest is now available. This is very convenient for the medical bag or for the diabetic patient. The case also contains a medicine dropper and a Galatest color chart. This handy kit or refills of Acetone Test (Denco) and Galatest are obtainable at all prescription pharmacies and surgical supply houses.

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163 Varick Street, New York 13, N. Y.



WHEN *Living Itself* PROVES DIFFICULT

Stamina and strength, essential to a joyous, optimistic outlook, are vitally linked to the nutritional status, and will quickly wane if undernutrition is allowed to develop. Zestful living and boundless energy are hardly compatible with nutritional deficiencies.

For the below-par patient whose inadequate nutritional intake is the responsible factor, Ovaltine as a dietary supplement can make a real contribution toward assuring nutritional balance. A good source of high-quality protein, readily utilized carbohydrate, well-emulsified fat, and essential vitamins and minerals, Ovaltine can prove a significant factor in restoring the desired state of optimal nutrition. Three glassfuls daily, made with milk as directed, provide appreciable amounts of essential nutrients as indicated by the table. The low curd tension of Ovaltine assures rapid gastric emptying, hence the appetite for regular meals is not impaired. Ovaltine is enjoyed as a beverage and between meals.

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Three daily servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	1.50 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.81 mg.
CALCIUM	1.12 Gm.	VITAMIN C	39.6 mg.
PHOSPHORUS	0.939 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.75 mg.

*Based on average reported values for milk.

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(equal parts of sulfa*thiazole* and sulfa*diazine*) **in one tablet**



TO REDUCE RENAL TOXICITY INCIDENT TO SULFONAMIDE THERAPY

Recent experimental and clinical studies[1,2] prove that administration of sulfathiazole and sulfadiazine in combination in equal parts reduces renal complications such as crystalluria, hematuria and urinary tract blockage, and is much safer than either drug used alone in whole dosage. Simultaneously, antibacterial activity and therapeutic efficacy are maintained.

COMBISUL-TD presents 0.25 gram sulfathiazole and 0.25 gram sulfadiazine — a total of 0.5 gram per tablet. No signs of renal toxicity have been encountered by use of this mixture and even crystalluria is infrequent. The indications for, and dosage of, COMBISUL-TD are the same as for either drug administered alone. Meningitis is an exception, for which COMBISUL-DM, a combination of 0.25 gram sulfadiazine and 0.25 gram sulfamerazine is available.

COMBISUL-TD available in 0.5 gram tablets. Bottles of 100 and 1000.
COMBISUL-DM available in 0.5 gram tablets. Bottles of 100 and 1000.

1. Lehr, D.: Proc. Soc. Exper. Biol. & Med. *58*:11, 1945.
2. Lehr, D.: In press.

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DISTRICT MEDICAL SOCIETY MEETINGS

WASHINGTON COUNTY MEDICAL SOCIETY

The Annual Meeting of the Washington County Medical Society was held January 9, 1946, at the Nurses' Home, Westerly Hospital.

The Treasurer's report was read, accepted and ordered placed on file.

Applications for membership were received from Dr. Thomas A. Nestor of Wakefield, and Dr. Joseph L. C. Ruisi of Westerly. The Board of Censors at a special meeting recommended that these men be admitted to membership, and they were approved at once.

Dr. Charles Farrell of Pawtucket spoke on the A.A.P.S. and plans to guarantee private practice. He urged all physicians to join the organization and support its program.

The Nominating Committee then presented a slate of officers for the coming year:

President ..... SALVATORE P. TURCO, M.D.
1st Vice-President ..... LOUIS MORRONE, M.D.
2nd Vice-President ..... SYLVESTER A. CAPALBO, M.D.
Secretary-Treasurer ..... JULIANNA R. TATUM, M.D.
Censor for 3 years ..... JOHN E. RUISI, M.D.
Auditor ..... A. L. MANGANARO, M.D.
Delegate for 2 years ..... JULIANNA R. TATUM, M.D.
Councilor ..... JOHN P. JONES, M.D.
Member of Public Policies Committee ..... L. C. CERRITO

These were voted on by one ballot cast by the Secretary.

The speaker of the day was Dr. John D. Hubbard who read a very interesting paper on "Carcinoma of the Breast." A discussion period followed.

After the meeting adjourned dinner was served at the Haversham Inn to twenty-five members and guests.

Respectively submitted,
JULIANNA R. TATUM, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A joint meeting was held by the Providence Medical Association with the Rhode Island Medical Society at the Medical Library on Monday, February 4, 1946. The meeting was called to order by Dr. Paul C. Cook, president of the Association, at 8:35 p.m.

The report of the Executive Committee was read by Dr. Frank W. Dimmitt in the absence of the secretary, and the following actions of the Committee were noted:

The Executive Committee authorized the President to appoint a committee of three members of the Association to study the question of a Telephone Exchange for the membership and to report back its findings to the executive committee.

The Executive Committee approved of a recommendation to send an inquiry card to every member to assist in a study of fee tables for medical services in the community.

The Executive Committee voted that effective January 1, 1946, members of the Association returning to Rhode Island after serving in the armed forces shall be excused from the payment of annual dues for a period of six months from the date on which they start civilian practice, and shall be assessed on a pro rata basis for the remainder of the year after the six months exemption period.

The Executive Committee appointed a committee consisting of Drs. John E. Donley, Roland Hammond, Peter Pineo Chase, Albert H. Miller, and Wilfred Pickles to initiate plans regarding the Association's centennial, and particularly to consider the question of a history of the Association in connection with this observance.

The Executive Committee recommended that a committee of Drs. William H. Foley, Frank B. Cutts and Herbert E. Harris be appointed to review the question of zoning regulations in certain areas on buildings suitable for physicians' offices.

Dr. Cook announced that he had appointed the following committees to prepare tributes for the Association membership to the memory of deceased members:

Drs. Joseph C. O'Connell and Dr. Thomas McOsker, for the late Dr. Edward Campbell; Drs. Herbert Partridge and William O. Rice for the late Dr. John M. Peters; Drs. Joseph Dowling and Edward A. McLaughlin for the late Dr. Michael B. Milan; and Drs. Bertram Buxton and John G. Walsh for the late Dr. Raymond Bugbee.

Reporting for the Executive Committee, Dr. F. W. Dimmitt announced that it recommended for

continued on page 233

Medications of Choice
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Auralgan
in ACUTE OTITIS MEDIA

Symptoms

Pain, fever, edema, leucocytosis, sense of fullness ond impaired hearing.

Treatment

Relief of pain ond inflammotion—*Auralgan.*

Action

Decongestant, analgesic, bocteriostatic.



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Treatment

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Formula

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Action

Deodorizes the dischorge, liquifies unheolthy gronulotions, bocteriostatic, permits normol epitheliolizotion.

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Complimentary quantities for clinical trial

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 231

election to active membership in the Association the following physicians:

Herman B. Marks
Hubert Holdsworth
George E. Charon
Barrito B. Mongillo
Eric Denhoff

A motion was made, seconded and passed that the nominees recommended by the Executive Committee be elected to active membership.

The business session of the Association completed, Dr. Cook called upon Dr. Joseph H. Ladd, vice president of the Rhode Island Medical Society, to conduct the remainder of the program. Dr. Ladd called for a report from the Secretary. Dr. Morgan Cutts, assistant secretary, reported the action of the House of Delegates in proposing certain amendments to the By-Laws. After a reading of the proposed changes Dr. Ladd called for a motion of acceptance. It was moved, seconded and passed that the proposed by-law changes be effected.

Dr. Ladd then introduced Major General Paul R. Hawley, assistant administrator of Veterans Affairs, in charge of medicine and surgery, who discussed the subject "Medical Care for the Veteran". After General Hawley's presentation, Dr. Herman C. Pitts, president-elect of the State Medical Society reported on "The Plan for a Voluntary Surgical Insurance Program for Rhode Island."

The meeting adjourned at 10:30 p.m.

Respectively submitted,
FRANK B. CUTTS, M.D., *Secretary*

WELCOME HOME!

The Rhode Island Medical Society reports the following Rhode Island physicians as honorably released from active duty, most of whom have resumed the private practice of medicine in this State as of March 15. Additional listings will be made each month and members are urged to report promptly upon their return to Rhode Island.

CLARENCE E. BIRD, M.D., 116 Waterman Street, Providence
NATHAN CHASET, M.D., 105 Keene Street, Providence
HAROLD L. COLLOM, M.D., 3188 Post Road, Apponaug
PALMER CONGDON, M.D., 211 Angell Street, Providence
ROBERT FARRELL, M.D., 57 Beacon Avenue, Providence
WILLIAM A. MCINTYRE, M.D., 652 Elmwood Avenue, Providence
GUSTAVO A. MOTTA, M.D., 164 Academy Avenue, Providence
LOUIS A. NORMANDIN, M.D., 240 Taunton Avenue, East Providence
JOSEPH SMITH, M.D., City Hall, Providence
EDWARD R. THOMPSON, M.D., Hall Building, 18 Exchange Street, Pawtucket
ARTHUR H. VAUGHN, M.D., 137 Warren Avenue, East Providence
HAROLD W. WILLIAMS, M.D., 129 Waterman Street, Providence

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1. "Glass Plastic Cast" by Roger Anderson, M.D., and Herbert R. Erickson, M.S., in *The American Journal of Surgery*, LXIX, 3 (September 1945), pp. 299-305.

2. "Fiberglas Used as a Root Canal Filling Material" by Harry Maeth, D.D.S., in *The Dental Digest*, LI, 10 (October, 1945), pp. 555-556.

3. "Significance of the Nitrogen Loss in the Exudate from Surface Burns" by John W. Hirshfeld, M.D., Harold H. Williams, Ph.D., William E. Abbott, M.D., Carl G. Heller, M.C., Ph.D., and Matthew A. Pilling, M.D., in *Surgery*, XV, 5 (May, 1944), pp. 766-773.

4. "Fiberglas Suture Material" by Roy Philip Scholz, M.D., and Philip S. Mountjoy, M.D., in *The American Journal of Surgery*, LVI, 3 (June, 1942), pp. 619-621.

5. "New Type Plasma Filter Will Aid in Prevention of Fatal Wound Shock" in *Surgical Business*, V, 5 (May, 1942), pp. 20-21.

6. "Rayable Gauze as a Factor of Safety in Surgical Operations" by Edward F. Lewison, M.D., in *Bulletin of the American College of Surgeons*, XXVII, 1 (January, 1942), pp. 39-40.

7. "The Effects of Fiberglas on Animal and Human Skin" by Marion B. Sulzberger, M.D., and Rudolf L. Baer, M.D., in *Industrial Medicine*, XI, 10 (October, 1942), pp. 482-484.

8. "Fiberglas Health Hazard Investigation" by Walter J. Siebert, M.D., in *Industrial Medicine*.

9. "Hazards of Exposure to Glass Wool, Glass Frit or Foam-Glass" by B. J. Hein, M.D., in *The Journal of the American Medical Association*, CXXIV, 3 (January 15, 1944), pp. 187-188.

10. *Report of the Director of The Trudeau Foundation*—1941 by LeRoy U. Gardner, M.D., last page, describing findings based on inhalation tests in which animals were exposed to glass fiber dust.

11. *Health Aspects of Fiberglas Materials*, 8-page brochure, published in April 1945, for plant physicians, industrial hygienists, safety engineers, and others interested in a documented summation of facts relating to the subject.

12. *Transcript of Remarks* on "Health Aspects of Fiberglas Materials" by W. G. Hazard, U.S.P.H.S. in *Proceedings of the Rhode Island Industrial Health Institute*, May 19, 1943.

13. "Safe Handling of Fiberglas in Shipbuilding" by Edward G. Ames in *1944 National Safety Congress Transactions*.

14. "Use of Fibrous Glass by the Army and Navy", by Major Hubert D. Keiser, A.U.S., in *Mining Technology*, VII, 3 (May, 1943), pp. 1-14. Contains a comprehensive description of manufacturing processes.

15. "Fibrous Glass Insulation: Health Aspects of", joint memorandum (December 30, 1942) of the Bureau of Ships and the Bureau of Medicine and Surgery (BUMED FS/838-1 (103)).

16. *Pioneering Uses of Fiberglas Materials in Medicine*, 16-page brochure describing ways in which Fiberglas is being used to solve medical problems.



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BOOK REVIEW

MEN WITHOUT GUNS. DeWitt MacKenzie. The Blakiston Company, 1945.

In my first introduction to this book I was reminded of the celebrated writer lecturing before a Providence audience several years ago mentioning in passing that the book, "Gone With The Wind", was a dangerous one to read if you were sick in bed, and all hands went up in the audience at the start of the question period as to why. He answered that if it accidentally fell on your chest it might crush you. This is the only fault to be found with this book but I do not see how it could be otherwise to allow for the beautiful illustrations.

Other books have been written depicting the work done by the medical corps in the war but none that I have seen contain such vivid pictures in such volume by well known artists who not only painted but lived the life they illustrate so well.

From the foreword by Major-General Kirk and the graphic description by DeWitt MacKenzie through the various theaters of war, you get the story behind what each artist portrays. It gives a report in both words and pictures of the magnificent and amazing work carried out by the entire medical department in World War II, showing advances made in medicine and surgery since the first World War. It shows the folks at home how the health of their loved ones in all branches is guarded and the excellent care given to the unfortunate soldiers who are injured.

Nothing better in pictures could ever be told than the wonderful sacrifices and courage of the Army Medical Corps carrying on in the face of all conditions and dangers. I can recommend this book to physicians but even more to the general public.

JOHN F. KENNEY, M.D., F.A.C.P.

BOOKS MISSING FROM LIBRARY

The Librarian reports the following books as missing from the Davenport Collection in the Miller Room at the library. The prompt return of these publications is requested.

Oliver Woodson Nixon—*Whitman's ride through savage lands, with sketches of Indian life.* 1905. (HISTORY)

John Duncan Quackenbos—*Illustrated history of ancient literature, oriental and classical.* N. Y., 1882. (HISTORY)

William Wallace Sanger—*The History of prostitution.* N. Y., 1898. (HISTORY)

Charles MacLaurin—*Post Mortem.* N. Y., 1923. (ADDRESSES, ESSAYS, MISCELLANEOUS)

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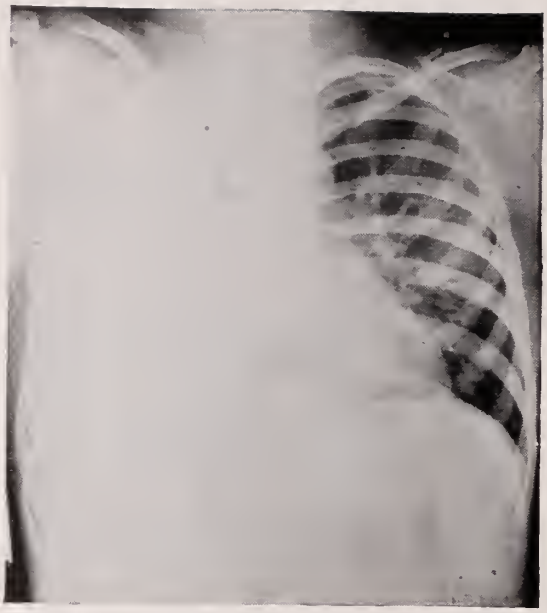
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Size of cavity, type of infection, and number of organisms determine the amount of penicillin to be administered in empyema. Usually 50,000 or 100,000 units in normal physiologic saline solution are injected once or twice daily directly into the empyema cavity after aspiration of pus or fluid. (Keefer, C. S., et al.: New Dosage Forms of Penicillin, J.A.M.A. 128:1161 [Aug. 18] 1945.) Treatment is by instillation, rather than irrigation, because penicillin requires at least 6 to 8 hours of contact for maximum effect.

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ANNUAL REPORTS
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PROVIDENCE MEDICAL ASSOCIATION
1945

Continued from February R. I. Medical Journal

AIR POLLUTION ABATEMENT

The following report is a continuation of that submitted at the May 1945 meeting and brings the committee's action to date.

On April 2, 1945, a very interesting and instructive paper was given at the Providence Medical Association Meeting by Dr. C. A. Mills, Professor of Experimental Medicine at the University of Cincinnati. Dr. Mills' subject was "Medical Aspects of Air Pollution". He found a higher incidence of pneumonia and pulmonary T.B. in the more heavily smoke polluted sections of Cincinnati. There was also a definite increase in cancer of the respiratory tract and a moderately higher incidence of stomach and rectal cancer in these areas.

On April 16, 1945, the Planning Committee proposed at the March 19 general meeting met. The committee is made up of the following members:

Miss Alice W. Hunt — Mr. George Hurley
Miss Georgia B. Lewis — Mr. Albert Harkness
Mr. Harry C. Rankin — Dr. B. Earl Clarke
Mr. Edward Winsor — Dr. Alexander Burgess
Dr. Edward S. Cameron

After a general discussion it was proposed that a good improved ordinance should be made up which would facilitate law enforcement. A subcommittee composed of Mr. Edward Winsor, Mr. Harry C. Rankin, and Dr. Cameron as chairman, was appointed to draw up a new ordinance.

This subcommittee has met on several occasions. It has received a very interesting report from Mr. John Vance of the Chamber of Commerce, who made a so-called "smoke abatement field trip", visiting the cities of Pittsburgh, Cincinnati, and Washington during the last summer. Mr. Vance concluded that the present Rhode Island law could be stripped down to a "mere skeleton of itself and serve a better purpose." He cited the very brief Washington ordinance which has proven effective.

The Committee has kept in touch with Mr. Philip Mancini, Providence City Public Service Engineer, who has been cooperative and from the results of his last dust collections feels that we are beginning to see some improvement in Providence. We hope to see some short articles in the daily press, written by Mr. Mancini, which would be of an educational nature to the general public and really help them with their fuel burning problems.

Mr. Fletcher Burton, president of Curran & Burton, Inc., kindly consented to serve with the subcommittee in a consulting capacity, when appointed by Dr. B. Earl Clarke, president of the Providence Medical Association.

A "Better Providence Meeting" sponsored by the Providence Chamber of Commerce was held at the Narragansett Hotel October 17, 1945. Among other Civic Problems, that of Air Pollution was given attention. A short talk was given by Dr. Cameron on the Health Aspect of Air Pollution, and after a panel discussion of the air pollution problem the following endorsements were made:

1. We endorse the active work for correction of air pollution being carried on by the Public Service Engineer's Department and urge continuous public cooperation.

2. We advise an educational program by Mr. Mancini, Public Service Engineer, by articles on combustion to home owners through the press.

3. We suggest that the Mayor appoint an advisory committee of not more than five to review the present smoke abatement ordinance and to consider if revision of the present ordinance or a new ordinance should be set up, and especially to consider the following changes:

continued on page 243

DEPARTMENT OF PUBLIC WORKS
OFFICE OF THE PUBLIC SERVICE ENGINEER
CITY HALL, PROVIDENCE, R. I.

Philip S. Mancini, *Public Service Engineer*

January 4, 1946

Dr. Edward S. Cameron
82 Waterman Street
Providence, Rhode Island

Dear Dr. Cameron:

Following are the results of our soot collection. The December sample is not ready:

1945 Tons (sq. mi.) per year

Location	April	July	Sept.	Oct.	Nov.
Biltmore Roof	5647	2123	1496	1216	762
	*859	*501	*736	*834	.....
Sessions St.	497	301	235	192	290
R. W. Park	305	179	336	221	**
Brown University	1467	388	531	629	**
School for the Deaf	336	117	247	197	**
Commercial High	756	990	436	394	**
Avg. Tons per sq. mile per year	703	412	420	411	.....

*Average (1930-1938)

**Lost samples due to weather conditions.

The Biltmore reconverted to oil during the latter part of October. The November reading seems logical. In computing the City average soot fall of tons per square miles per year, I used the average (1930-1938) soot fall in the respective months for the Biltmore instead of the actual readings—because the soot jar is located right at the chimney—and using soft coal the precipitation at the chimney is not representative of the area.

Yours very truly,

PHILIP S. MANCINI,
Public Service Engineer

"don't smoke"...

IS ADVICE HARD FOR PATIENTS TO SWALLOW!

May we suggest, instead, *SMOKE "PHILIP MORRIS"?* Tests* showed 3 out of every 4 cases of smokers' cough cleared on changing to PHILIP MORRIS. Why not observe the results for yourself?

**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*

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ERYTHROL TETRANITRATE MERCK in Angina Pectoris

It is generally agreed that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of nitrites. For this purpose, the rapidly acting nitrous and nitric acid esters, amyl nitrite and nitroglycerin, are considered most useful.

For prophylactic purposes—to control anticipated paroxysms—the *delayed but prolonged action* of erythrol tetranitrate is more effective. Erythrol tetranitrate, because of its slower *and more prolonged action*, is also considered preferable for the purpose of preventing nocturnal attacks.

The vasodilatation produced by Erythrol Tetranitrate Merck begins 15 to 20 minutes after administration, and lasts from 3 to 4 hours.

The properly timed administration of a vasodilator having a sustained effect may prevent the following episodes of angina pectoris:

- The man who finds it necessary to stop and rest when he walks to the train in the morning.
- The man who suffers "indigestion" and "gas" on exertion, or after a heavy meal.
- The man who has pain in his chest and arms, and weakness upon any anxiety, anger, or nervous strain.



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"There are many opportunities for practical dietary application of the advances in our understanding of protein economy. The provision of liberal protein diets in instances where the value of protein has been demonstrated offers both prophylactic and therapeutic advantages to the patient."

PREGNANCY AND LACTATION

"Protein is one of the essentials for which there is greater need. . . . The growth needs of the fetus must be met and if adequate dietary protein is not supplied, the mother's protein stores will be drained. . . . The demands for protein during lactation are even greater. . . . One further reason for providing a liberal supply of protein . . . lies in the favorable effect which protein has upon calcium absorption."

DISEASES OF THE KIDNEY

". . . actual improvement in the well-being of nephritic patients may be observed following the use of high-protein diets both in adults and children. In some instances functional capacity of the kidneys has been reported to improve on such a regime. . . . For the treatment of nephrosis the same dictum holds true, only to a greater extent. . . ."

DISEASES OF THE LIVER

"For many years carbohydrate alone has been considered the one substance capable of providing protection for the liver cells. . . . Protein has now been shown to be considerably more effective in this respect. . . . The effect of protein on the liver is not only reparative, but also definitely protective against the agents known to be toxic to the liver. . . ."

PEPTIC ULCER

". . . a rather high incidence of moderate hypoproteinemia in peptic ulcer cases has been reported. Any ulcer, be it peptic, infectious, or the result of pressure and circulatory changes, represents a loss of tissue and requires protein for rebuilding. . . ."

OTHER CONDITIONS

"In old age, for instance, all too often the food intake deteriorates to soft foods of limited variety. . . . Yet in such instances the same protein requirements for maintenance of the numerous body functions are still in effect. . . . Protein may also be lost because of its excessive breakdown under the influence of fever or heightened body metabolism, and negative nitrogen balances may develop, as for instance in hyperthyroidism. . . .

"With the demonstration of this increased importance of protein dietetic therapy, it can only be recommended that there be an increased use of high-protein diets."

Among the protein foods of man meat ranks high not only because of the percentage of protein contained, but primarily because the protein of meat is of high biologic quality, applicable for every protein need.

*Anderson, Geo. K., M.D.: *The Importance of Protein in Diet Therapy*, J. Am. Dietet. A. 21:436 (July-August) 1945.

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ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

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ANNUAL REPORTS

continued from page 239

(1) Inclusion of all classes of fuel-burning equipment.

(2) Provision of authority to establish regulations on the installation and operation of equipment.

(3) Provision for control of the emission of dust as well as smoke.

It was further concluded that industrial and other consumers of solid and liquid fuels be urged to exercise close supervision of their present combustion equipment, and to install such available devices as will help reduce smoke and control fly-ash and other elements contributing to air pollution.

It was encouraging to see a paragraph in the December 1, 1945 issue of *Electrical World,* an Engineering Journal. It was stated "that Narragansett Electric Co., Providence, has plans for installation of smoke abatement equipment in generating Station on Manchester Street with work to be carried out over a period of several months. Total cost reported in excess of $3,000,000." Mr. Harry C. Rankin, who is a member of our subcommittee, is an Engineer at the Narragansett Electric Co.

At subsequent meetings of the subcommittee it was felt that a good enabling act which would pave the way for an improved ordinance and be flexible enough so that all parts of the State would be in a position to make an ordinance for their particular locality would be very desirable. Mr. Edward Winsor has put together a brief but seemingly comprehensive enabling act and it is expected that the new Civic Committee on Air Pollution appointed by Mayor Roberts in November will urge its adoption and passage by the General Assembly.

Trusting that the above resume of your Committee will help you in appraising the situation as of to date,

EDWARD S. CAMERON, M.D., *Chairman*
ALEX M. BURGESS, M.D.
ANTHONY CORVESE, M.D.

RESOLUTION URGING USE OF SURGICAL INSURANCE PLAN AND OF SOCIETY FACILITIES IN PLANNING MEDICAL CARE FOR VETERANS

"WHEREAS the Veterans Administration has expressed a desire and a willingness to cooperate with existing agencies in the task of meeting the medical needs of veterans, and

WHEREAS the Rhode Island Medical Society contemplates the establishment of a voluntary, prepaid surgical insurance program for the residents of the State, therefore,

BE IT RESOLVED that the Rhode Island Medical Society record its desire that the Veterans Administration utilize the services and the facilities of such a prepaid surgical insurance program when it is established to provide for surgical needs of veterans, and be it further resolved that it is the wish of the Society that its organized facilities and the professional services of its membership be made available to the Veterans Administration to assist in meeting the medical needs of veterans until such time as the surgical insurance program is developed, and the veterans' hospital is constructed in Providence."

. . . . Adopted by the House of Delegates of the Rhode Island Medical Society, Jan. 31, 1946.

INJECTION TREATMENT OF HEMORRHOIDS

continued from page 196

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[6] Martin, C. F.: The Injection Treatment of Internal Hemorrhoids. Am. Med. 8:9, 365-70, Aug. 27, 1904.

[7] Dukes, C., and Anderson, H. G.: Treatment of Hemorrhoids by Submucous Injections of Chemicals, Brit. Med. J. 2:100, 1924.

[8] Hayden, E. P.: Internal Hemorrhoids: Injection Treatment. New Eng. J. Med. 203: 218-220, 1930.

[9] Balch, F. G. Jr.: New Eng. J. Med. 212: 57-60, 1935.

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[17] Rosser, C.: Hemorrhoids, Journal Lancet 53, 21, 584, 1933.

[18] Tuttle, J. P.: Quoted by Collier F. Martin, M.C.

[19] Kilbourne, N. D.: Internal Hemorrhoids: Comparative Study of Treatment by Operative and Injection Methods: Survey of 62, 910 Cases. Am. Surg. April, 1934.

[20] Yeomans, F. C.: "Proctology" D. Appleton-Century Co., N. Y. p. 148, 1929.

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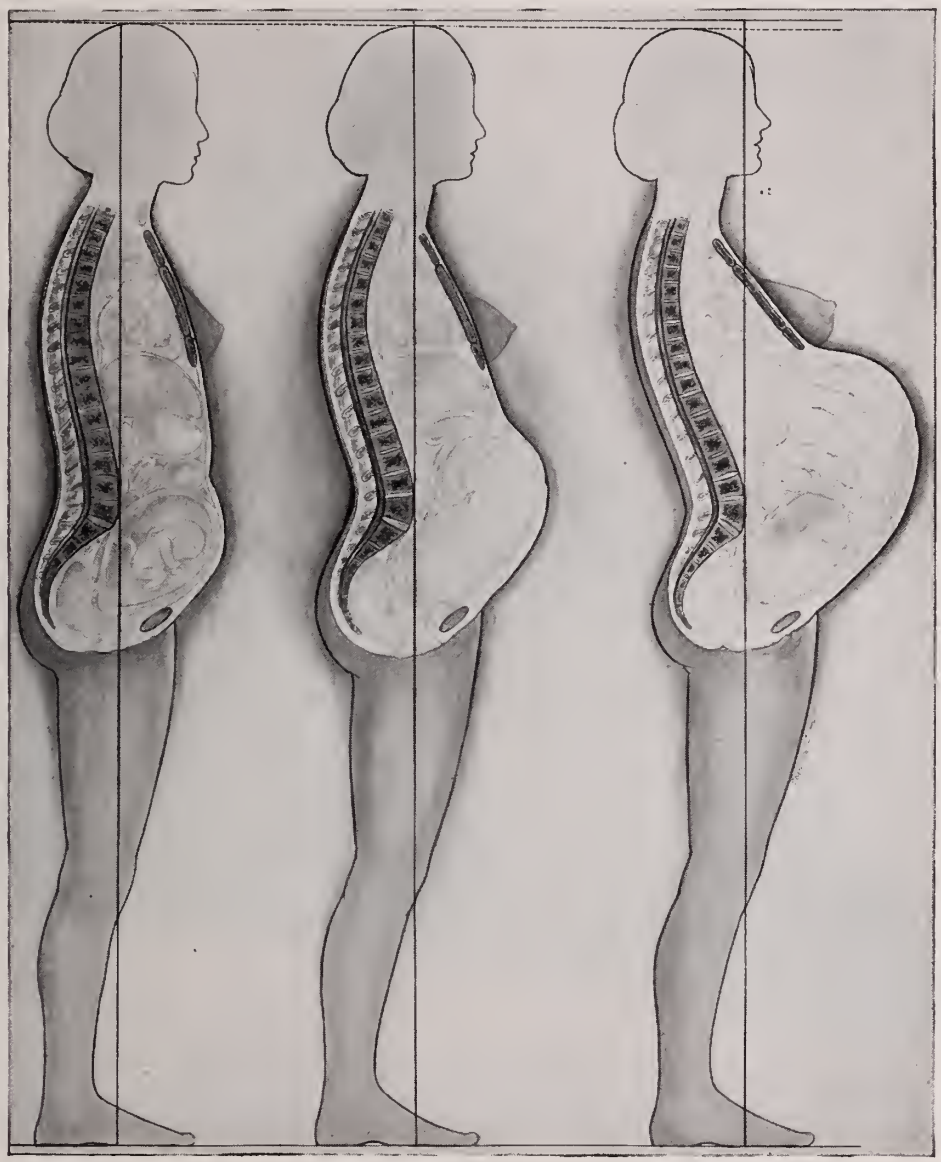


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• STUDIES FROM LIFE MODELS DURING PREGNANCY • Illustration by Charlotte S. Holt



4 LUNAR MONTHS 7 LUNAR MONTHS 10 LUNAR MONTHS



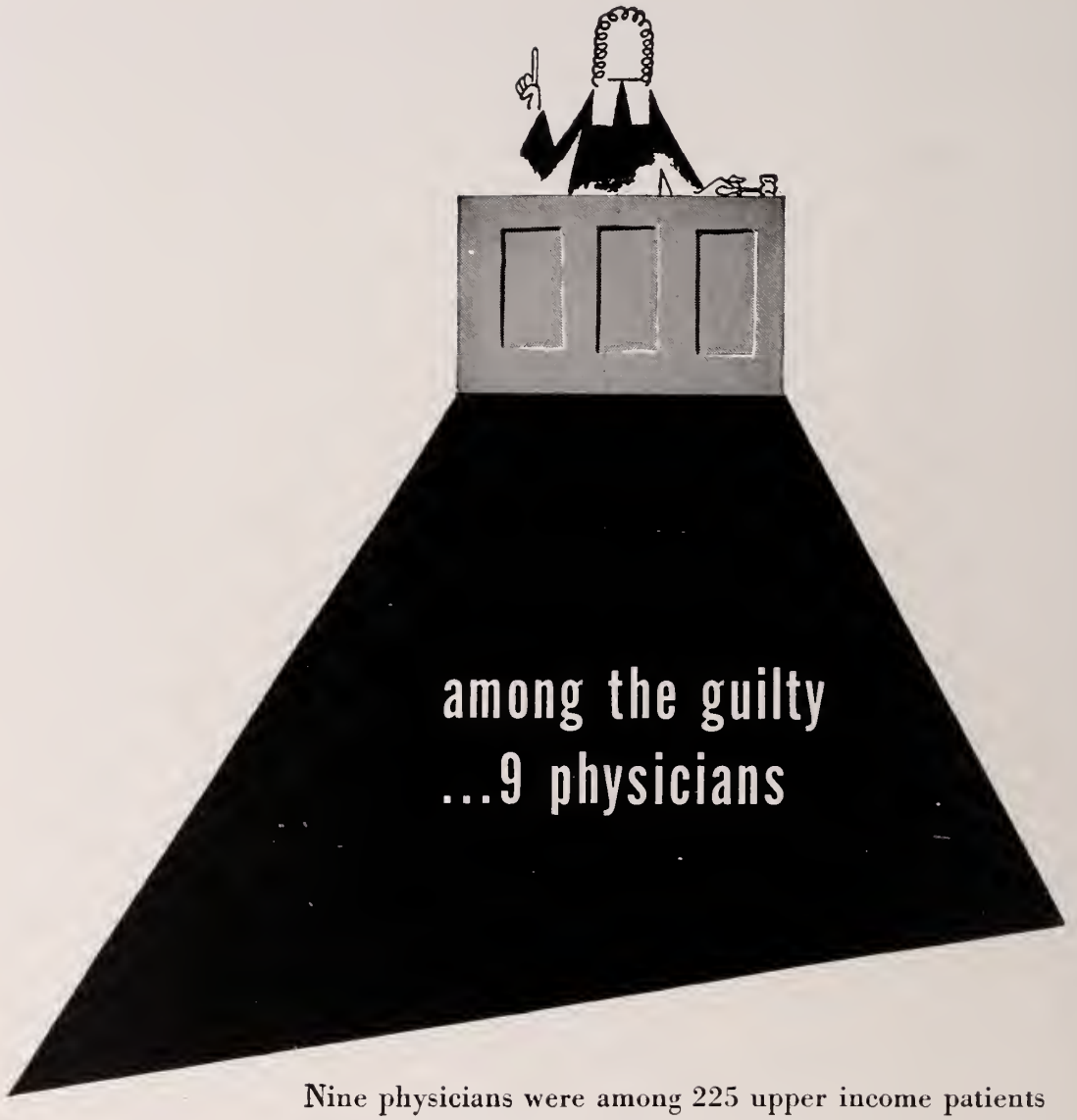
The postural changes during pregnancy are due to the compensatory backward shift of the center of gravity caused by forward pull of the load of the pregnant uterus.

Note the retracted shoulders, carriage of head (pride of pregnancy), and the accentuation of the natural lumbar lordosis which relieves abnormal tension on back and leg muscles.

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1. New England J. Med. 228:118 (Jan. 28) 1943.
2. J.A.M.A. 129:613 (Oct. 27) 1945.

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INCOME-TAX CREDIT *for* CHARITY PRACTICE *of* PHYSICIANS*

Extension of Remarks

OF

HON. CLARE BOOTHE LUCE

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES, *Monday, March 4, 1946*

MRS. LUCE. Mr. Speaker, under leave to extend my remarks in the RECORD, I include the following editorial from Current Comment for February 9, 1946:

INCOME-TAX CREDIT FOR CHARITY PRACTICE OF PHYSICIANS

The value of the services rendered annually by physicians of this country in the treatment of the indigent sick for which they receive no compensation has been estimated as in excess of $300,000,000. Recognition of this tremendous contribution made by physicians for the public good is reflected in a bill, H. R. 5296, introduced in the Congress January 30 by Representative CLARE BOOTHE LUCE, of Connecticut. The measure provides that physicians, surgeons, and dentists, commencing with the taxable year 1946, shall be allowed an additional credit as a deduction on their income tax equal in terms of percentages to that portion of their time each year which is devoted to charity, free clinic work, and public research work. The Commissioner of Internal Revenue will prescribe by regulation, it is contemplated, the method of computing such time and the proof which shall be required in substantiation.

At the time the bill was introduced Representative LUCE had inserted in the CONGRESSIONAL RECORD a statement embodying the justification for her sponsorship of this legislation. In connection with the many proposals being made for various kinds of governmental control of medicine, she said:

"None of these proposals is a logical development of the American system of recognizing, promoting, and rewarding individual choice and achievement. In our earlier history pioneer medicos were rewarded for their frequently ill-paid devotion by a very special place in the community, high respect from their fellow citizens and patients, and payment in lovingly prepared delicacies where cash was scarce. Those times have largely vanished. To become a doctor, a surgeon, a dentist now requires some 8 or 9 years of unremunerative and expensive schooling. Until he has completed all this, usually by the time he is 29 or 30, the doctor cannot even begin to earn his own bread and salt, much less begin to repay himself for the costs of learning his profession."

After referring to the fact that all reputable physicians give a considerable portion of their time to the treatment of patients who are unable to pay for the services in any way except by gratitude, the statement continues:

"Surveys as to the amount of these unpaid services indicate that the percentages range from around 30 to 45 of all treatments given. This is a direct contribution on the part of the physician, surgeon, or dentist to the public welfare. In addition are the hours spent without pay in public research work, on hospitals' boards, and on boards of charitable organizations. All this must be chalked up to professional devotion, since it results in no return and often requires the practitioner to lengthen his working day to 15 or 16 hours or more in times of epidemic. There are no limits possible on a doctor's working day."

Because of the facts so well set forth in her statement, Representative LUCE believes that the recognition contemplated by her bill is fully justified. This measure is pending before the House Committee on Ways and Means, where, it may be assumed, it will be given consideration by the committee in connection with its program to revise the income-tax law.

*Reprinted from the *Congressional Record* — Appendix Issue of March 4, 1946

IN INFECTIONS COMPLICATING PREGNANCY, DELIVERY, and the PUERPERIUM

ACCUMULATING evidence* points to penicillin as a therapeutic agent of choice not only in puerperal and postabortive sepsis but also against infections complicating pregnancy (when the causative organisms are penicillin-sensitive). Since penicillin crosses the placenta into the fetal circulation, it may affect penicillin-susceptible infection in the fetus.

*Davis, C. H.: Gonorrheal Arthritis Complicating Pregnancy Treated with Penicillin, Am. J. Obst. & Gynec. 50:215 (Aug.) 1945.

Hudson, G. S., and Rucker, M. P.: Gas Bacillus Infection of the Uterus Treated with Penicillin, Am. J. Obst. and Gynec. 50:452 (Oct.) 1945.

Woltz, J. H. E., and Zintel, H. A.: The Transmission of Penicillin to Amniotic Fluid and Fetal Blood in the Human, Am. J. Obst. & Gynec. 50:338 (Sept.) 1945.

Mitchell, R. McN., and Kamincster, S.: Penicillin; Case Report of a Patient Who Recovered from Puerperal Sepsis Hemolytic Streptococcic Septicemia, Am. J. Surg. 63:136 (Jan.) 1944.

White, R. A.: Puerperal Sepsis Treated with Penicillin, Southern M. J. 37:524 (Sept.) 1944.

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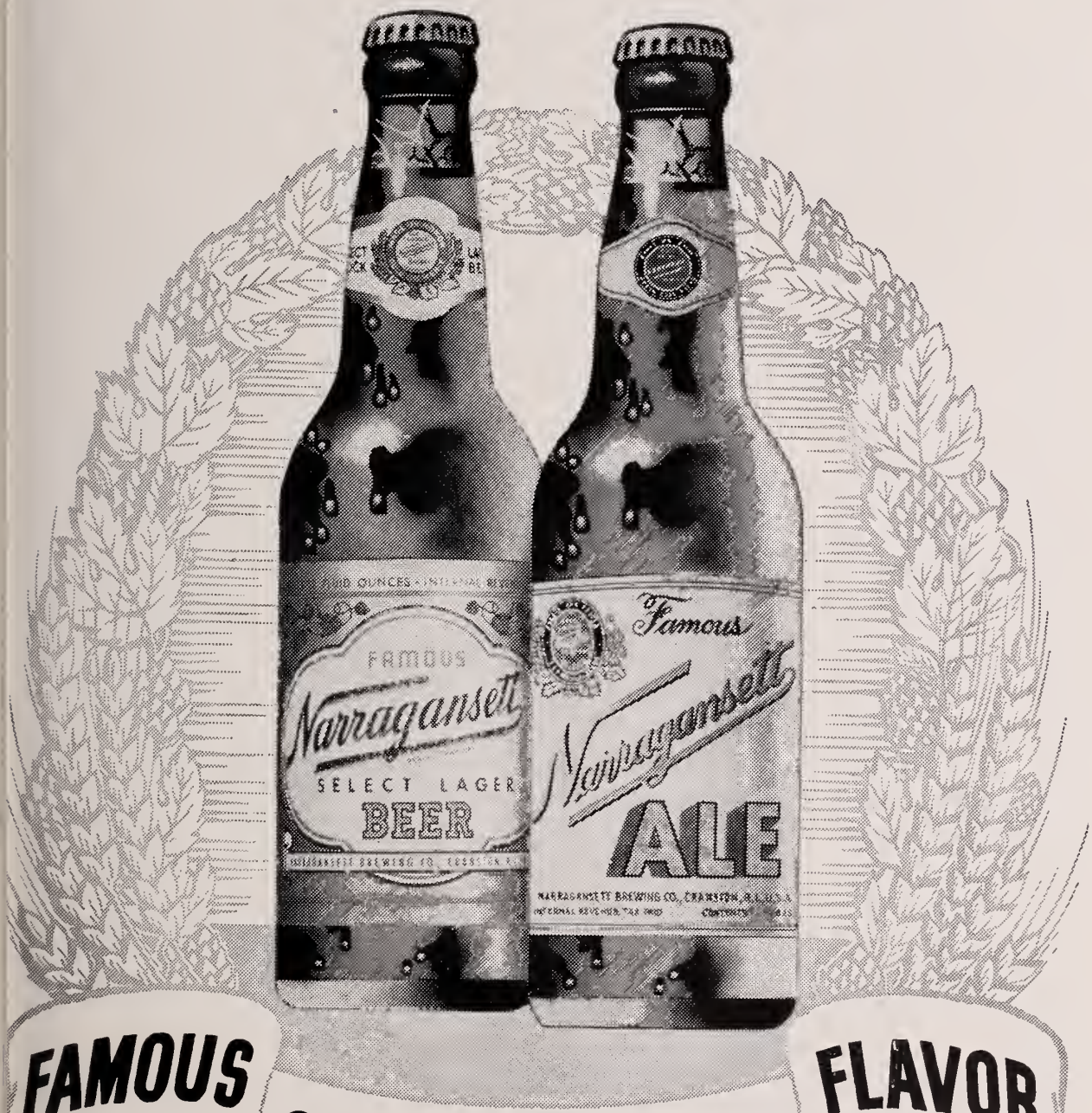
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May 15-16 (*Wednesday and Thursday*)
Rhode Island Medical Society
Annual Meeting ..... At Providence

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Volume XXIX, No. 4

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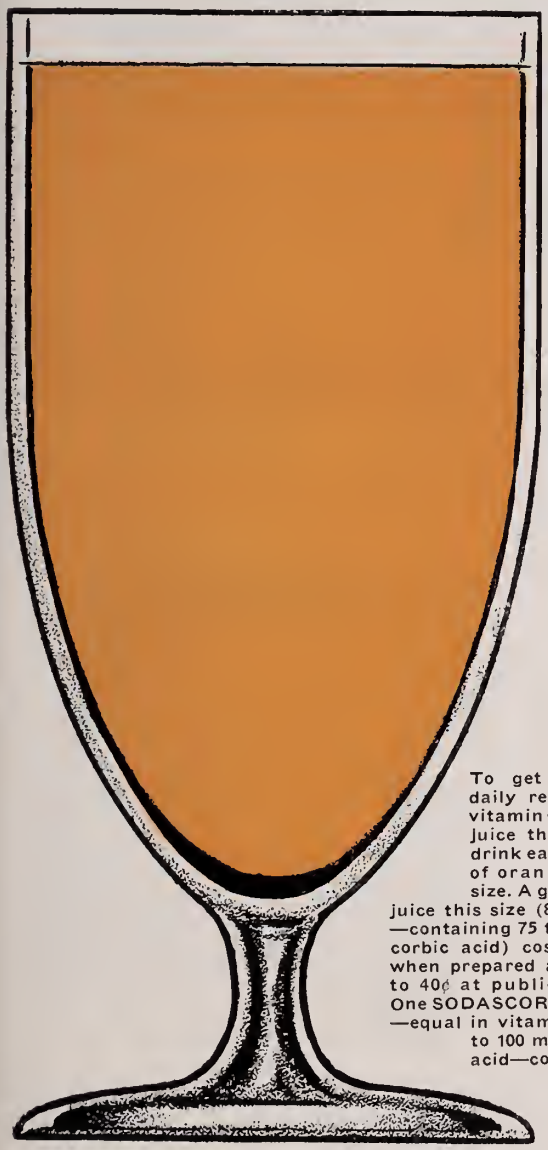
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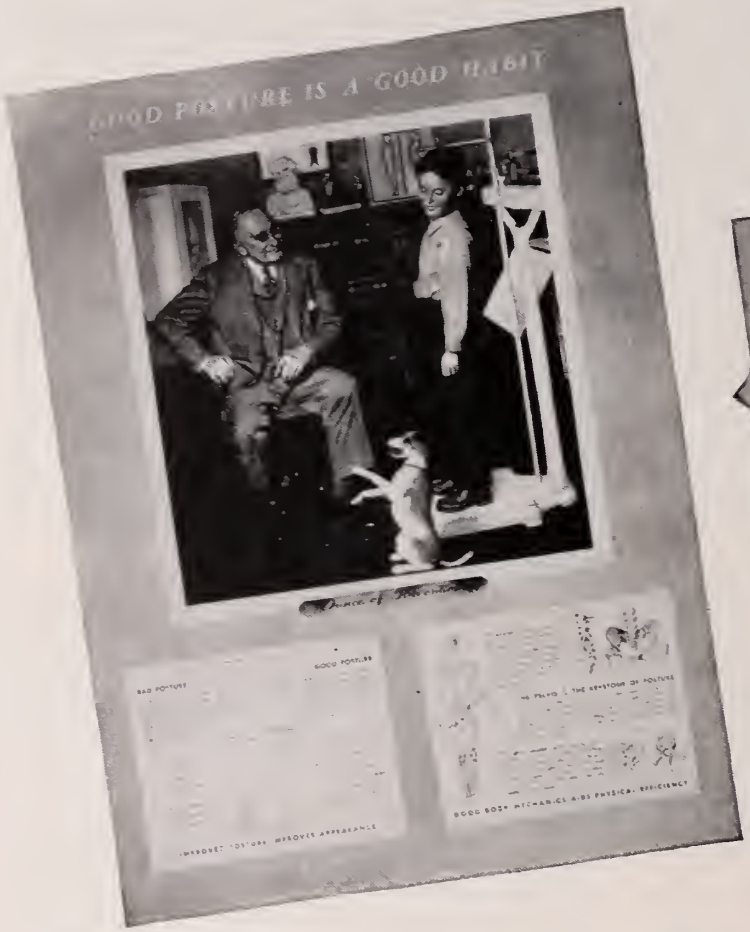
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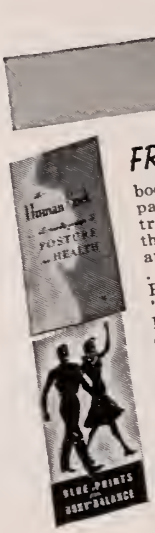
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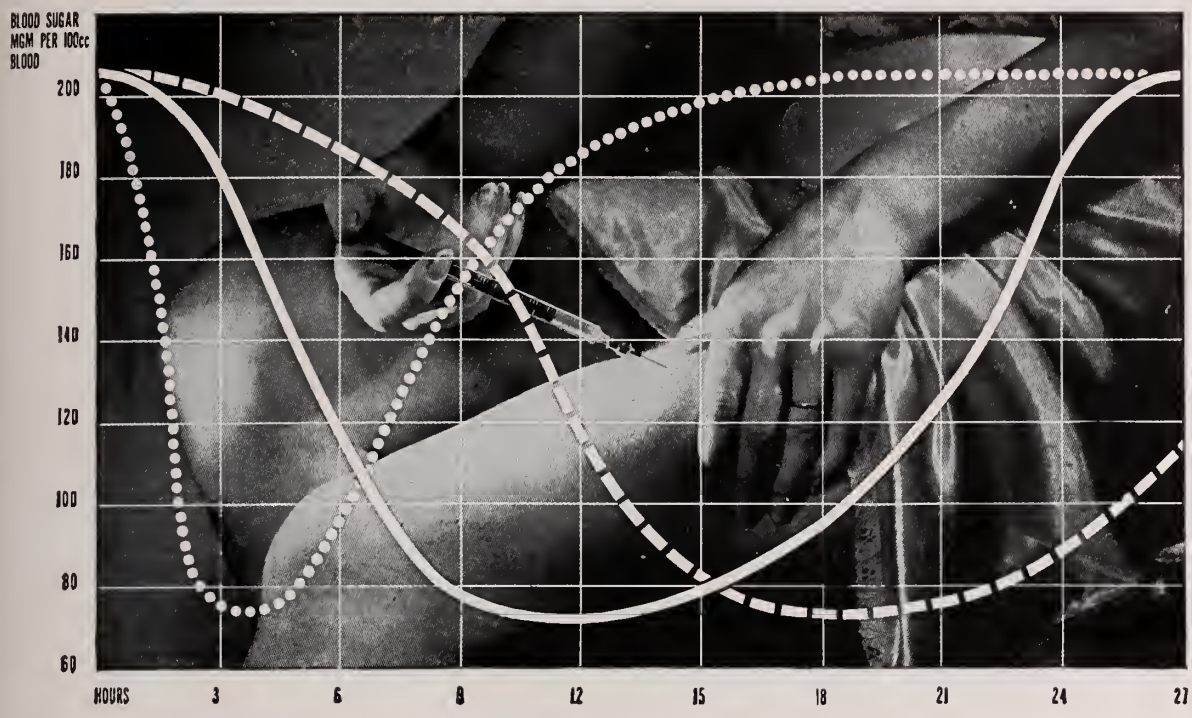
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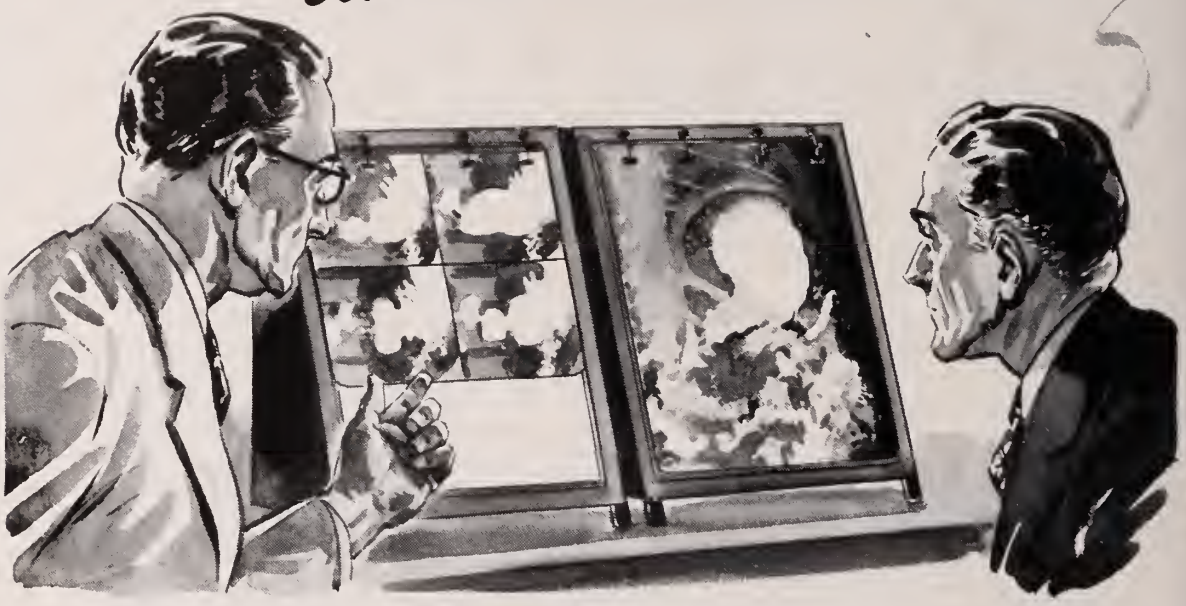
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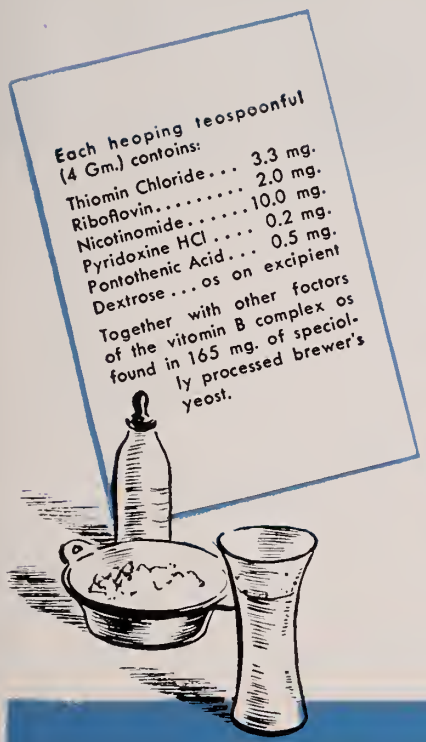


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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXIX APRIL, 1946 NO. 4

BRACHIAL PLEXUS BLOCK — *100 Consecutive Cases*

EDWARD DAMARJIAN, M.D.

The Author, *Edward Damarjian, M.D., of Providence, R. I. During the War, Chief Anesthetist, 48 Evacuation Hospital, and later on the anesthesia staff at Valley Forge (Pa.) and Chief Anesthetist at Woodrow Wilson (Va.) General Hospitals.*

THIS paper consists of a series of 100 consecutive cases of brachial block regional anesthesia done at this hospital. All cases were done for the Orthopedic Service.[1] The type of surgery varied from a simple excision of a scar or capsulotomy to excision of head of the radius, removal of carpal bones, sequestrectomy of radius, ulna, or lower two-thirds of humerus, amputation of fingers, surgery about the elbow joint, and removal of bone plates from forearm.

No failures were encountered in these 100 consecutive cases. The reason for this success, we believe, is due entirely to the premise that to accomplish a successful brachial block, the anesthetist must necessarily obtain paresthesia, and, secondarily, he should be sufficiently acquainted with his anatomy of peripheral nerve distribution to be able to inject the remaining cords of the brachial plexus by using his original paresthesia site as his guide. Ideally, then, the operator should obtain three paresthesias, one for each of the three cords, to obtain a good brachial block. We definitely disapprove of merely depositing a given volume of an anesthetic over the first rib, as suggested by many authors, and then anxiously hoping that the first stroke of the surgeon's knife will not elicit pain. The correct method, we feel, is to stay with your patient until you have obtained the proper paresthesia and the correct anesthesia for the expected surgery before the patient leaves the anesthesia room. This can be done with the least possible trauma in capable hands, but the promiscuous probing with the needle by the novice, searching for paresthesia, is not considered good technique. If correctly done, with paresthesias obtained, the anesthetic will take effect immediately and there is no waiting period as popularly believed. The anesthesia will last from 1½ to 2½ hours and the dangers of inhalation or intravenous anesthesia are avoided.

The brachial plexus is formed by the anterior divisions of the last four cervical and first thoracic nerves to form three main trunks called upper trunk, middle trunk, and lower trunk. Each of these three trunks divides into anterior and posterior divisions and then the divisions reunite to form the cords which lie beneath and cephalad to the clavicle. The lateral or upper cord which is formed by the anterior divisions of the upper and middle trunks extends peripherally to form the Musculocutaneous nerve, and also sends another branch to join with a branch of the medial cord to form the Median nerve. The other branch from the median cord extends to form the Ulnar nerve. The posterior divisions of all three trunks unite to form the posterior cord which, in turn, without dividing like the other two cords, extends to form the Radial and Axillary nerves.

From this anatomical distribution, one can determine, upon supraclavicular injection, which cord has been injected by noting the peripheral paresthesia produced. Furthermore, once a paresthesia has been effected, one can tell by orientation whether to direct his needle medialy or laterally to inject the other two cords. For instance, if the operator's original injection produced a paresthesia of ulnar distribution indicating medial cord injection, then he knows that he must direct laterally to inject the posterior cord for radial distribution, and again still more laterally to produce paresthesia of the lateral cord. Then again, if he injects and produces paresthesia of radial distribution showing that he has injected the posterior cord, then he must direct the needle both laterally for the lateral cord, and medially for the medial cord. Finally, if

continued on next page

[1] Appreciation is extended to Lt. Col. Leonard Barnard, M.C., Chief of Orthopedics, for his cooperation in obtaining this series of cases.

he produces paresthesia of the lateral forearm on his original injection, showing that he has injected the lateral cord to produce the paresthesia of the Musculocutaneous nerve, he must then inject medially for the posterior cord and again still more medially for the medial cord.

Since the operator must ascertain from the distribution of paresthesia resulting from his original injection as to which cord he has injected, it is important that he have exact knowledge as to the peripheral distribution of each of the three cords injected. To insure against possible error, we have prepared a large size diagram of the brachial plexus with peripheral distribution in color corresponding to the cord that enervates the area. This allows for quicker decision and less possible chance for error. It is important then to know that the entire medial side of the arm, forearm, and 1½ fingers both dorsally and ventrally are supplied by the medial cord. In the upper arm the area from mid-humerus to the axilla is supplied by the Intercostobrachial, which originates at T-2 and therefore is not anesthetized in a brachial block. Then again, one must know that the Median nerve supplies the lateral area of the forearm (Musculocutaneous) to the wrist, medial half of the volar surface of the forearm, including 3½ fingers of the hand, and also the dorsum of the distal half of the three middle fingers, including the mesial surface of the thumb. Finally, the posterior cord supplies the lateral and posterior area of the upper arm, the midportion of the dorsum of the forearm, and the lateral area of the dorsum of the hand, including 3½ fingers, but including only the proximal half of the three middle fingers.

From this nerve distribution then, it is important that both lateral and medial cords be injected for a Median nerve distribution, the posterior cord for the radial distribution, and median cord for Ulnar nerve distribution. However, unless the operative site is clearly a limited area like an amputation of a finger, or capsulotomy of a phalangeal joint, one finds that at least two paresthesias must be obtained, and we further compensate for the absence of the third paresthesia by depositing a small volume of the anesthetic solution at the transverse process of the cervical vertebra corresponding to the cord that has been missed. For instance, the transverse process of C-5 is injected for the upper cord, C-6 for the posterior cord, and C-7 for the medial cord. This method, we feel, modifies the idea of Labat, who describes the deposition of the anesthetic at Chassaignac's tubercle (6th transverse process) in one of his techniques. The transverse processes are palpated by their relation to the cartilaginous landmarks of the neck. C-5 is opposite the crest of the thyroid cartilage, and C-6 is opposite the cricoid cartilage. In those instances where only one paresthesia can be obtained, two injections of solution are made at the tip of the transverse processes of the corresponding cervical vertebrae.

The technique consists always of a supraclavicular approach. The length of the clavicle is not used as a guide because of its variability. If the Subclavian artery is easily palpable, the site of injection is one fingerbreadth lateral to it and also a fingerbreadth above the clavicle. If the artery is palpated with difficulty then we use the Scalenus Anticus muscle as a landmark. A shortened No. 22 spinal needle, with a very short bevel to prevent piercing the nerve cord, is used directing the thrust towards the first rib. The necessary depth varies from ½" to 1½" and the midlle and index fingers should be used as a guide on the shaft of the needle to prevent deeper penetration. If the rib is not contacted, then the direction of the needle is at fault. In no instances have we observed any unusual reactions, although in some instances, have obtained arterial blood without causing any harm. Only one skin puncture is made and all paresthesias and transverse cervical vertebrae injections are made from this one skin entry.

The long-clavicle type, flat-chested patient is easily blocked. It is the short-neck, barrel-chested patient with acute S-shaped clavicle that gives the most trouble. It has been our experience in these cases to direct the needle superiorly instead of towards the first rib, and attempt to inject the cords as they are formed by the six various divisions of the trunk midway between the cervical vertebrae and the first rib. Invariably, in these patients, the 1st rib forms a very acute angle and the convexity of the rib extends hardly beyond the sterno-clavicular junction. The rib may be missed by the needle if the usual supraclavicular attempt is made by the operator. Furthermore, in this type of patient, paresthesias are frequently easily encountered when injections are made toward the transverse processes of the cervical vertebrae and not toward the first rib.

Only 5 cc of solution (metycaine 1½%) is deposited at each paresthesia site. Thus, a brachial block is completed with a total volume of 15 to 20 cc of solution. We have noted that a larger volume of solution will tend to cause a complete motor paralysis of the arm. This type of complete paralysis is not desired by the orthopedic surgeon, especially when the surgeon needs some voluntary motor control by the conscious patient to help him identify structures. However, in surgery involving considerable trauma, the effects of the larger dose is preferable. When the anesthetic effect of the block begins to disappear, the motor function will return while sensory anesthesia continues to persist for sometime.

We have found that Metycaine 1½% is more

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OUT-PATIENT ELECTRIC CONVULSIVE THERAPY*

LAURENCE A. SENSEMAN, M.D.

The Author. *Laurence A. Senseman, M.D., of Saylesville, R. I. Director, Fuller Memorial Sanitarium, South Attleboro, Mass. Assistant in Neuro-psychiatry, Memorial Hospital, Pawtucket, R. I.*

SHOCK therapy is by no means a new form of treatment. Various forms of it have been used ever since the treatment of mental illnesses was first begun. Some of these earlier forms of therapy can now be reviewed with amusement and others with dismay. It was not until the last two decades, however, that shock therapies in the form of insulin-coma, metrazol and electric-convulsive treatments have constituted a dependable weapon in the psychiatrists armamentarium for the alleviation of the distressing symptoms of the psychotic patient and more specifically the pathologically depressed individual. Ever since Sakel's[1] work in 1928 with Insulin, there has been a growing interest in shock therapy. Meduna[2] introduced metrazol-convulsive therapy in 1934 and in 1938 Cerletti and Bini[3] convulsive therapy by the passage through the brain of an electric current. Due to its convenience, the rapidity with which the patient is induced into a convulsion, and its margin of safety, this form of treatment has become increasingly popular with many psychiatrists and institutions in the treatment of the mentally sick. More recently electric shock therapy has been given to patients on an out-patient basis,[4,5] mostly for the milder forms of illnesses that do not require institutional supervision. In this way many early cases are relieved of their distressing complaints making hospitalization unnecessary.

It is my purpose to review a small series of cases which we have completed on an out-patient basis at the Fuller Memorial Sanitarium in South Attleboro, Massachusetts. The type of equipment used at this institution is the Reiter Electrostimulator[6]. This apparatus is considered to induce a milder convulsion by delivering a smaller current for a little longer period of time than other types of electric shock apparatus. The average dosage is from 60-70 millamps and the average time from 1-3 seconds.

Preliminary to the application of the treatment, about 11:00 a.m., the patient is permitted to eat a light breakfast, to be accompanied by a responsible relative or friend and to sign a permit blank. After bladder and bowels have been evacuated, tight clothing loosened and shoes removed, the patient lies on a rigid truck with a pillow under the lumbar spine for hyperextension. The electrodes are placed over the motor area, usually on the left side, one just above the ear and the other on the vertex. Salt jelly is then placed under the electrodes and a nurse with rubber gloves holds them in place. A second nurse is stationed by the upper extremities and a third by the lower extremities to control excessive motility of these parts during the seizure. A mouth gag is placed between the teeth after all dentures have been removed. The electrical current is then passed through the patient's head and the convulsive seizure induced. There is usually a quick tonic phase of the convulsion during which the body is hyperextended and the arms and legs are rigid followed by a tonic-clonic convulsion lasting approximately 60-100 seconds. The patient then becomes flaccid and respiration is shallow until deep breathing begins relieving a temporary cyanosis. With prolonged apnea artificial respiration is helpful. The patient responds to questioning in about 3-5 minutes after the treatment and on some occasions may be confused, but rarely excited. Occasionally a patient becomes nauseated and vomits or presents incontinence. Most of them have a short period of amnesia which rapidly clears. Following the seizure they remain lying down for the next hour. As a rule the patients are able to leave the Sanitarium after a period of an hour to an hour and a half. We usually advise that they go home by automobile and remain quiet for the rest of the day, though some younger patients have resumed work on the same day. No complications were encountered in this series of cases.

It is of interest to note that with a number of our patients we have given very few treatments, partly because of the mildness of their illness and with others because of their fear of the treatment and failure to return for further administrations. Our best results have been obtained in those who have received three to six treatments and these usually have been depressed patients.

Discussion

There are certain disadvantages of this form of therapy. The most important is the fear associated with the treatment which keeps the patient from

continued on next page

*Presented at Butler Hospital Staff Conference, February 5, 1946.

returning after some degree of improvement is obtained. Then, too, the patient is not under close supervision following treatment and one must rely on others to interpret the results to a large extent. We believe that the number of beneficial results obtained, however, outweigh these disadvantages.

Of this group of patients treated on an outpatient basis, 6 were males and 24 were females. One hundred twenty-three treatments were given or an average of 4.1 treatments per patient, with a range from 2 to 11 treatments. Ages varied from 16-71 with the largest number (10) between 30 and 40 years of age. Our results may be summarized as follows:—

9 or 30.0% were greatly improved
13 or 43.4% were improved
8 or 26.6% were unimproved

Of the depressed group of 17 patients, 9 or 46%, were considered greatly improved, 6 improved or 40%, and 2 or 13% unimproved.

An illustration of the response of a depressed patient after three electric-convulsive treatments:

Case No. 4, age 54, white, male, adult who gave a history of being depressed in 1919 and spending one year in a mental institution. In 1929 he was again depressed and in 1938 spent three months in a mental hospital. He stated that he was well up until one week previous when he began to lose his appetite, experienced jumpy sensations in his abdomen, and was obsessed with the idea of suicide and felt compelled to do so. He also stated that he had many morbid fears and had lost some weight. He was unable to sleep at night, taking 2-3 Seconals at bedtime.

On physical examination his blood pressure was 150/80; pulse, 88. E.N.T. not remarkable. Chest had some musical rales typical of an asthmatic condition. Heart was normal, not enlarged, regular rhythm. Abdomen was negative for masses and tenderness. There was, however, a small lump in the left epididymis.

continued on next page

	Name	*Age*	*Sex*	*Diagnosis*	*No. E.C.T.*	*Results*	*Remarks*
1.	R. W.	43	F	Manic Depressive—Depressed	3	greatly improved	Depressed every 6-8 mos.
2.	C. L.	40	F	Manic Depressive—Depressed	5	greatly improved	Improved after 1st E.C.T.
3.	E. S.	32	F	Manic Depressive—Depressed	3	greatly improved	Numerous previous episodes
4.	H. C.	55	M	Manic Depressive—Depressed	3	greatly improved	Four previous episodes lasting 4-6 mos.
5.	A. L.	61	M	Manic Depressive—Depressed	3	greatly improved	Depressed 3 mos. 1944 Hospitalized. Depressed 1 mo. 1945, a bit overactive after 3ECT.
6.	L. T.	28	F	Depressed	3	improved	Responded after 1st treatment
7.	A. W.	51	F	Depressed	3	improved	Previous episodes and this time asked for E.C.T.
8.	H. G.	57	F	Depressed	3	greatly improved	Further treatment not necessary
9.	M. H.	37	M	Depressed	6	greatly improved	Attempted suicide before E.C.T. Has worked 1 yr. but again depressed
10.	L. S.	37	F	Depressed	3	greatly improved	Several previous depression
11.	M. M.	71	F	Depressed	5	improved	Several yrs. of depression
12.	J. M.	39	F	Depressed	2	improved	Responded after 1st E.C.T.
13.	A. S.	61	F	Depressed	11	unimproved	Been depressed 7 years
14.	A. B.	35	F	Depressed	3	unimproved	Failed to keep further apts.
15.	H. W.	34	F	Psychoneurotic Depression	7	improved	Severe agitated depression with marked ambivolence
16.	J. C.	48	F	Psychoneurotic Depression	4	improved	Much more push and interest in home
17.	A. A.	60	F	Involutional Melancholia	4	greatly improved	Estrogenic substance given until discharged as well
18.	W. P.	47	M	Psychoneurosis	5	unimproved	Severe with cardiac neurosis
19.	M. M.	38	F	Psychoneurosis	6	unimproved	Institutionalized later
20.	R. B.	42	M	Psychoneurosis	5	improved	Depression element was relieved, later given more E.C.T. at another hospital and is now well
21.	V. P.	29	F	Psychoneurosis	3	improved	Obsessive compulsive neurosis
22.	A. C.	57	F	Psychoneurosis	4	improved	Coughing every 5 seconds, complete relief of cough
23.	P. M.	39	M	Schizophrenia	2	unimproved	Failed to return
24.	O. D.	16	F	Schizophrenia	7	unimproved	Sent to State Hospital (better after Sod. amytal)
25.	E. B.	44	F	Schizophrenia (Paranoid)	5	unimproved	Sick 10 yrs. and been in State Hospital. Family felt there was improvement
26.	B. G.	20	F	Schizophrenia (2nd episode)	3	unimproved	Transferred to another hospital
27.	G. W.	34	F	Schizophrenia	4	improved	Now working
28.	R. J.	25	F	Schizophrenia	5	improved	Was able to return to home in Minnesota
29.	B. M.	22	F	Schizophrenia (2nd episode)	3	improved	Able to return to work
30.	T. K.	31	F	Schizophrenia	4	improved	Delusions were much better controlled

OUT-PATIENT ELECTRIC CONVULSIVE THERAPY

continued from preceding page

This patient was given his first convulsion on 3/21/45 and again on the 25th and again on April 12. At this time he stated that he felt very well and wanted to return to work. He also indicated that he felt he was coming out of the depression as he knew what the sensation was, having experienced this on three separate occasions before. He also stated, "you can give me another electric shock treatment but I feel that I am now well." He was able to return to work at this time, and to date has carried on his usual work as treasurer of a large manufacturing concern.

An illustration of the psychoneurotic response to three electric-convulsive treatments:

Case No. 21, age 29, wife of an Ensign in the Navy who had a marked obsessive compulsive neurosis and who spent most of her time preparing for bed, but feeling that such preparations were never quite complete. She was very ritualistic in her behavior, spending a great deal of time with her hair, fingernails and make-up. She was nervous, apprehensive and tense, though pleasant, cooperative and rational at all times. No psychotherapy was attempted as she was referred by another doctor for electric-shock treatment. This was given at the Sanitarium on four separate occasions. Her husband stated that he felt that she was improved, as she spent less time taking care of her person, and became more interested in her surroundings, especially in her home. After three treatments she was able to get out and mix with others socially. This was quite a departure from her previous routine of limited activities and while she is not completely well considerable improvement is apparent.

Conclusions

1. Electric shock therapy can safely be given on an out-patient basis.
2. Depressed patients showed the most favorable response in this series of cases.

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BRACHIAL PLEXUS BLOCK

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desirable than Procaine 2%. The length of time that anesthesia persists with Procaine is quite unpredictable, varying from 50 minutes to 1½ hours; whereas, Metycaine lasts from 1½ to 2½ hours.

For example, let us suppose our candidate for brachial block is a robust patient of short stature, short neck, and S-shaped clavicle. We first attempt the ordinary supraclavicular approach directing the needle towards the first rib. If the rib is easily contacted, we continue to locate our three cords. If the rib lies medially at the sterno-clavicular junction, we direct the needle towards the cervical vertebrae and attempt to cause paresthesia of the cords at a higher level closer to their origin from the divisions of the nerve trunks. From our diagram we know that injection of the medial cord not only blocks the Ulnar nerve, but also part of the nerve fibers that go to make up the Median nerve. Now if paresthesia of the lateral cord is missed, we know that part of that cord is blocked because of the contribution it receives from the already blocked medial cord. Then, to insure a good block, 5 cc of the solution is deposited at the tip of the transverse process of C-5. If our original paresthesia involved the lateral cord and we had missed the paresthesia of the median cord, then we again realize that we have blocked the Musculocutaneous nerve and only part of the Median nerve, because this nerve also receives a contribution from the medial cord. In this instance, we deposit 5 cc of the solution at the tip of the transverse process of C-7. Chassaignac's (C-6) tubercle is used for a missed posterior cord block. A good index of posterior cord block is the isolated area of supply of a small patch of skin over the dorsum of the first interosseus space, ennervated by the Musculospiral nerve. All injections are made from the original supraclavicular skin puncture.

Complications

As we have mentioned previously, we have encountered no frank failures, but have had to supplement the block toward the latter stages of the operation. This has only occurred in 7 cases, and these have all occurred with 2% Procaine. In another 8 cases, intravenous morphine was given for apprehensive patients who originally desired to be put to sleep. In those cases that were supplemented, we used Pentothal 2½%. In our previous paper[2] we noted that only .44 cc/min of intravenous Pentothal was necessary for patients who previously had a regional block.

We had no serious complications. In three instances, patients complained of vague paresthesia sensations for 3 days. Two patients complained of

[2] Pentothal Anesthesia—Journal of Anesthesiology. August, 1945.

continued on page 277

RHODE ISLAND BLOOD-PLASMA PROGRAM

(The American Red Cross is furnishing dried blood plasma without charge for use in civilian medical practice. This material was prepared from blood collected by the American Red Cross for the Army and the Navy and has now been declared surplus to their needs. Supplies of this surplus plasma are provided to State Departments of Health by the American Red Cross for distribution to all physicians licensed to practice medicine and surgery and to all acceptable hospitals for use without charge for the product.

The standard army-navy package consists of a sealed outer carton containing two metal cans. One holds the bottle of dried plasma, the other the distilled water for reconstitution of the plasma. The necessary tubing, needles, and other equipment required for reconstitution and administration of the plasma are also contained in the two metal cans. Instructions for reconstitution and administration are lithographed on the outside of the metal cans. Most of the packages also contain a report form to be filled out and mailed to the Army or Navy Medical Center. This report form is not to be used for local or state studies and is not to be mailed to the Army or Navy. Instead you are to use the form supplied by the State Department of Health.)

In accepting the responsibility to act as Sponsoring Agent for this area, the Rhode Island Department of Health has devised a program that resolves itself into two phases; (1) distribution of plasma and (2) establishment of a blood-plasma bank.

1. *Distribution*

At the commencement of this program, each hospital and maternity home licensed by the State and those operated under its auspices will be allotted one plasma unit for each four beds utilized for acutely ill patients. Each physician licensed by this department to practice medicine and surgery will be allotted one plasma unit.

The hospital allotments will be delivered to them by the ordinary avenues at the disposal of this department, aided by the motor corps of the local chapter of the American Red Cross.

The physicians may obtain their unit by applying at the various hospitals where they have staff appointments, or they may obtain it directly by calling at the Division of Narcotic Drugs and Pharmacies, State Office Building, or at the various district health units of the Department of Health located in Woonsocket, West Warwick and Bristol.

To obtain an original issue or a replacement of a unit, each hospital and physician must fill in the form supplied by the Department of Health. The purpose of this form is to keep an accurate inventory of supplies on hand and too, the expiration date of that plasma which is at large at the hands of the hospitals and physicians.

No charge whatever is to be made to any patient for the plasma supplied under this program. It is understood, however, that the institutions and/or physicians may justly charge for the professional services entailed in the administration of the plasma.

2. *Blood Bank*

At present the Department of Health has no facilities for the storage of whole blood, the processing of blood to recover dry plasma or the fractionation of either blood or plasma. Massachusetts has such facilities, and it is not amiss to hope that at a future date Rhode Island will be so equipped. In the interim it is suggested to the various institutions and physicians that for each unit of plasma used, the patient be solicited to procure or provide a blood donor. This donor will give an equal amount of whole blood to the physician or institution participating in the blood-plasma program.

Whole citrated blood may be preserved under aseptic conditions for seven to ten days with refrigeration. At the end of this period it may still be processed into dry plasma or fractionated. Blood-plasma which has reached its expiration date may also be fractionated. At the present time we have information that any of these above-mentioned processes can be done by the larger pharmaceutical houses at a cost in the neighborhood of $15.00 per 250 cc. unit. It will be quite understandable that this would prove an expensive procedure considering the fact that blood-plasma is now available free of charge to any patient regardless of their ability to pay. However, by following the above-mentioned suggestions, all institutions in our State should be able to have on hand at all times a quantity of fresh whole citrated blood and blood-plasma. Even if the blood must be discarded at the end of ten days the institution will have the added insurance of having had it available for emergency use.

INDICATIONS FOR TRANSFUSION*

Indication	Whole Blood		Plasma or Serum	
	Choice	State (fresh or preserved)	Choice	State (fresh liquid, stored liquid, frozen, dried)
Shock due to hemorrhage (traumatic shock)	First[1]	No preference	Second	No preference
Shock with hemoconcentration — Initial treatment (burns, crush syndrome, and abdominal injuries)	Second	No preference	First	No preference
Hypoproteinemia	Second	No preference	First	No preference
Acute and chronic anemias	Imperative	No preference	Not indicated	
CO poisoning and methemoglobinemia	Imperative	No preference	Not indicated	
Immune therapy	Second	No preference	First	Fresh liquid, frozen, or dried
Deficiency of complement	Either	Fresh	Either	Fresh liquid, frozen, or dried
Deficiency of prothrombin	Either	Fresh	Either	Fresh liquid, frozen, or dried
Leukopenia and thrombocytopenia	Imperative	Fresh	Not indicated	
Hemophilia	First	Fresh	Second	Fresh liquid, frozen, or dried

[1] The recommendation of first and second choice is made on the assumption that both blood and plasma are immediately available.

* Table adapted from OCD Technical Mannual, "The Operation of a Hospital Transfusion Service."

BRACHIAL PLEXUS BLOCK

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paresthesia of ulnar distribution without sensory or motor loss, and the paresthesia of both of these patients lasted for three weeks. Since orthopedic surgery was done under pressure tourniquet, it is questionable as to whether the block or the pressure tourniquet contributed to these paresthesias.

One other patient complained of chest pain after returning to his ward. X-ray showed a small pocket of air beneath the dome of the right pleura. Patient's symptoms disappeared in two days. No other complications were noted among the rest of the patients that were blocked and no instances of "reaction" to the anesthetic drug occurred.

Summary

We have presented a series of 100 consecutive brachial blocks. For repeated successful blocks, it is necessary that an operator have a good knowledge of the anatomy of the brachial plexus and its exact peripheral distribution. Furthermore, paresthesias must be elicited to insure proper block anesthesia in every case. We feel that this type of anesthesia eliminates many of the hazards that would be encountered in inhalation or intravenous anesthesia. Brachial blocks have become popular among the patients of this hospital and many requests are made for this type of anesthesia in preference to the popular Pentothal.

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WEDNESDAY---MAY 15

THURSDAY---MAY 16

R. I. HOSPITAL REFRESHER COURSES FOR VETERAN-PHYSICIANS

STANLEY S. FREEDMAN, M.D.

The Author. *Stanley S. Freedman, M.D., of Providence. Assistant Physician, Department of Pediatrics, Rhode Island Hospital.*

SPONSORED by the Post-Graduate Medical Education Department of Tufts Medical School, and in conjunction with several other hospitals, the R. I. Hospital has opened its clinical and teaching facilities in Pediatrics, Pediatric Surgery, and Allergy to a small, enthusastic group of recently discharged Medical Corps Officers. The men were New England physicians whose military duties prevented them from keeping up with advances in non-military medical subjects. The course included many topics and extended over a period of 12 weeks. It originated in Boston and ended in Providence. It included Medicine which was given at the Joseph H. Pratt Diagnostic Hospital; Surgery at the Boston City Hospital; and Obstetrics at the Lying-In Hospital of Providence. When this group completes its studies, a second "wave" of physicians is expected to arrive, and the process will be repeated.

The Pediatric Department and its staff, headed by Dr. William Buffum, and assisted by members of other departments conducted the course. Lectures, discussions, demonstrations, and ward rounds were held. The lectures were informal and were conducted in an atmosphere of mutual exchange of knowledge and information, the students often expressing their ideas and relating previous experiences.

Dr. Harold Calder gave a scholarly review on the subjects of tetany, diseases of metabolism and infant feeding. Dr. Henry Utter gave an inspiring talk on Diseases of the New Born. Dr. Robert Lord spoke on Special Problems encountered in pediatric practice. Dr. Reuben Bates dwelt on the problems of pylorospasm and pyloric stenosis. The Coeliac Syndrome, its classification, differential diagnosis, and management were covered by Dr. Herman B. Marks. Dr. Maurice Adelman returned from Florida just in time to give a two hour lecture on haematology, and Dr. John Langdon tackled nephritis and nephrosis. Respiratory Diseases and their present day management, were discussed by Dr. Arthur R. Newsam. Dr. Kalei Gregory's talk on preventive pediatrics was practical and up to date, including the latest reliable information on this vital subject.

Epidemic diarrhea of the new born and its tragic consequences is only too well known to all of us. It was Dr. William S. Bell who made a thorough and impressive presentation of this important subject. Dr. Edward West conducted ward rounds and demonstrations at the Charles V. Chapin Hospital. A motion picture depicting isolation-technique and treatment of contagious diseases was very instructive. A complete review of congenital and rheumatic heart disease was rendered by Dr. Walter T. Zimdahl.

The Surgical, Orthopedic, and Eye Departments contributed generously to the course. Dr. Wilfred Pickles lectured on Pediatric Neuro Surgery, paying particular attention to such problems as subdural hemorrhage in the neo-natal period, spina-bifida and hydrocephalus. Dr. Kenneth G. Burton discussed the diagnosis and treatment of congenital orthopedic anomalies, with emphasis on hip dislocation and hip infection. The surgical treatment of pyloric stenosis and intussusception was described by Dr. Frank B. Littlefield.

Dr. Frederick Stevens took up the subject of cataract and strabismus, and Dr. Lee Sannella described lacrimal sac infection in infancy.

A most interesting program on Neuropsychiatric Disorders in Childhood was presented at the Emma Pendleton Bradley Home in which Dr. Charles Bradley and his staff participated.

In the realm of Allergy Drs. William Buffum and Stanley Freedman delivered several lectures and demonstrations. Dr. Buffum with his usual enthusiasm opened with a general statement on the nature of allergy. Then followed a detailed talk on bronchial asthma and a presentation of several difficult cases. Dr. Freedman took up pollinosis and perennial vaso motor rhinitis. The latter was discussed in relation to pulmonary allergy in general. A demonstration in the technique of cutaneous testing was given in the Out-Patient Department.

Five medicos took the first course. They were Dr. Joseph Colman from Mansfield, Mass.; Dr. Sam Klouber from Boston; Dr. John F. Dougherty from Bath, Maine; Dr. Charles Moors from Rochester, N. H.; and Dr. Stanley R. Lenfest from Waldoboro, Maine. All were overseas veterans of World War II. One wore the Purple Heart. All expressed gratitude for the "kindly reception and excellent instructions" they received at the Rhode Island Hospital.

RINGWORM OF THE SCALP

(Due to interest and enthusiasm of Dr. William B. Cohen and Dr. Carl S. Sawyer, both members of The Dermatology Department at the Rhode Island Hospital, we have learned of the importance of the following subject and are able to give you this interesting resume.)

THE hair is woman's crowning glory and the appearance of a grey hair or the loosening of a hair shaft in its follicle is a calamity. The balding man is ever conscious of his receding hairline and is often envious of his more fortunate brethren who have a heavy mane at the age of sixty. However, parents are not always as watchful of their children's scalps as they are of their own. Or more likely, they are not cognizant of disease. Consequently it is the responsibility of the doctor to recognize disease of the scalp and preserve that important function of growing hair until time, worry, and the genes make his efforts fruitless.

The Dermatology department at the Rhode Island Hospital would like to bring to the attention of the medical profession at large the recent increase in the number of cases of Tinea Capitis or ringworm of the scalp in children seen in the Out-Patient department. During the past five months the number of new cases seen is more than can be considered sporadic. Most of these patients are Negro or Portuguese children who come from a small section of Providence near Fox Point, but there have also been cases from other sections of the City. The number of cases has not reached and is not likely to reach the epidemic proportions reported in other larger cities, but the definite increase in numbers is a warning to all physicians to be watchful for this condition.

Tinea Capitis is a disease primarily of children though it does occur occasionally in adults. It is important to recognize and treat the infection early because of its contagiousness and because untreated the disease may go on to permanent baldness.

The disease may be caused by several fungi, the most common of which in this section of the country is Microsporum Laposum, the so-caled "animal type" or the species which is also pathogenic for animals. The species Microsporum Audouini (human type and not as pathogenic for animals) is much less common in the Eastern states. Other organisms such as Achorion Schonleinii, which causes favus, and the Trichophytons are still less common but must be considered. Bald, crusted, scaly and pustular areas may very likely be ringworm.

The leions caused by M. Lanosum and the Trichophytons in general tend to be inflammatory with pustulation and boggy induration. The lesions start as papules surrounding a hair, spread peripherally and coalesce to form large patches in which may be seen broken off hairs.

The lesions caused by M. Audouini and by Achorion tend to be less inflammatory with less oedema and more scaling. This type is of greater infectivity, spreading from child to child and is usually the organism involved in epidemics of ringworm of the scalp. The more inflammatory types caused by M. Lanosum are less contagious, less likely to lead to permanent baldness, and occasionally heal spontaneously. This type of Tinea heals readily with local application of fungicides and daily washing.

M. Audouini causes an infection which is particularly resistant to treatment and nearly always requires X-ray epilation. Untreated, these cases may have permanent bald patches.

It is fortunate that nearly all the cases seen in this clinic have been caused by M. Lanosum and have been amenable to local treatment. There is little chance of the disease assuming epidemic proportions, but this fact does not lessen our responsibility in recognizing the disease early and instituting proper treatment.

It is recommended that:

1. a careful inspection of the scalp be included in the routine examination of school children.
2. a recognized case be excluded from school.
3. a suspected case be subjected to microscopic and cultural studies by sending a good number of the broken-off infected hairs, which are easily pulled out, to a laboratory to confirm the diagnosis and determine the causative organism.
4. the hair be clipped very closely.
5. the patient wear a stocking cap at all times. It may be changed and washed daily.
6. the parents be instructed in daily manual epilation in the infected areas followed by application of a suitable fungicidal preparation.
7. cases resistant to treatment or caused by the human type of organism be given X-ray epilation before permanent alopecia occurs.

Pediculosis Capitis and impetigo of the scalp are more common diseases and are easily recognized, but it takes only a little more care in examination to notice that in Tinea there are no nits and that the hairs are broken off.

The RHODE ISLAND MEDICAL JOURNAL

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SICKNESS ACT AMENDMENTS

(At the time the following editorial was written the legislation to which it has reference (see page 286) had been passed by the House of Representatives and referred to the Senate Committee on Labor. As the Journal goes to press we are informed that the Senate reported the amendments out with approval.

The Editors)

In May, 1943, when the state cash sickness compensation act was amended to alter its original purpose, Dr. Emery M. Porter, then President of the Providence Medical Association, cited in MEDICAL NEWS, official publication of the Association, the wide implications of the amendments, and the dangers involved. Dr. Porter received little support from the Board administering the program, or from the public at large; on the contrary, he was criticized for his views. Last month, however, the special commission appointed by Governor Pastore substantiated what Dr. Porter had so clearly forseen three years ago.

The legislation introduced as the result of the Commission's report remedies some of the problems, and postpones to a future date others. Of particular significance however, is the provision in the new amendments for the creation of a cash sickness advisory committee of seven members representing labor, the general public, the medical profession, and the general assembly. This new committee is to review the activities of the administration of the sickness fund monthly, file quarterly reports with the Board, and an annual report to the Governor containing recommendations as to the administration, management and operation of the fund. Here then, is belated recognition of the fact that the program is a community enterprise and not merely a state project subject to the administrative desires of a politically-appointed board.

Of particular interest to the medical profession is the amending of the definition of sickness long advocated by the State Medical Society. The new wording provides that an individual shall be deemed sick when he is unable to perform his *regular or customary work.* Now physicians are obligated to testify on the report form that the patient *is unable to perform any services for* wages, a most restrictive provision in view of the purpose of a temporary disability program.

The House of Delegates of the Rhode Island Medical Society, in February, 1945, recommended that complications of pregnancy be compensable under the sickness program, but that pregnancy should not. It also recommended that if maternity benefits were to be allowed the beneficiary should receive them for the six weeks prior to and for the

six weeks immediately after the due date of delivery of a child. The Commission recommended, and the legislation introduced provided for, a total of fifteen weeks of benefits due to sickness resulting from pregnancy, whether such sickness be prenatal, postnatal, or a combination of both; provided, however, that these limitations shall not apply to unusual complications arising as a result of childbirth. Just what is to determine an "unsual complication" is apparently left to the discretion of the Board administering the act.

Taking cognizance of the fact that an appeal of a claimant upon the discontinuance of his benefits by the Board under the existing law goes back to the same board, the Commission recommended and the new amendments provide for, a special board of review of three members, one of whom shall be a representative of the medical profession, one the public, and one of employees. However, the only appeals that would reach this review board would be those on which the unemployment compensation board had not reached a *unanimous* decision. The problem here is twofold. On the one hand the unemployment compensation board can be unanimous in the majority of its decisions, thus resulting in very few appeals reaching the new board of review, and thereby subverting the purpose of the amendment. On the other hand, if every claimant aggrieved by any decision of the UCB takes his case to the board of review, the latter board will necessarily find itself on full-time duty.

The compromise would appear to be the position advanced by the representatives of the State Medical Society at the hearings before the Commission. One or more impartial medical representatives might sit with the UCB at appeal hearings and assist in the reaching of a fair decision, since most appeals are based on claim of physical inability to resume work.

On one other point must we take exception. That is the proposed amendment that to safeguard the fund an educational program *must* be undertaken by the UCB to publicize the need for accident prevention and the preservation of health, the need for industrial employment to provide the best available safeguards for workers, and the need for appropriate sanitary facilities. This is not the task of the unemployment compensation board. It is the work of the state and municipal health departments, and the statutes already provide for the mechanism to carry out all of these phases of health education. While it may be commendable that the UCB cooperate in the work of health education, within the scope of its own sickness act program, yet it would appear far more advisable that the framework of the state health department be strengthened to achieve this purpose. The new health code allows the state director of health to establish a division of health education, and it also clarifies and improves the provisions relative to the control of industrial health in this state.

If the cash sickness compensation program is to expend its funds for public health and for industrial health education work, then it is reasonable to give consideration to the proposal that some thoughtful study be given to the coordination of the cash sickness compensation program and the curative center of the state labor department under a separate Public and Industrial Health Commission under the direction of the Governor.

ELECTROENCEPHALOGRAPHY

Rhode Island physicians who have followed the development of electro-encephalography as a new and valuable diagnostic technique in neuro-psychiatry will be interested in learning that on March 1st at a meeting held in Hartford the Eastern Association of Electroencephalographers was organized. This is the first official association of scientists engaged in this work to be organized in this country and should be of assistance in the pooling of research results and the development of standards of application, diagnosis, and terminology in this new field. Approximately thirty-five scientists from the Atlantic seaboard region were present at this organization meeting and elected Dr. Robert S. Schwab of Boston as Chairman and Dr. Charles A. Stephenson of Hartford as Secretary, with future plans for meeting approximately every two months.

Rhode Island was represented at this meeting by Donald B. Lindsley, Ph.D., Director of Psychological Laboratory and Electroencephalographic Research at the Bradley Home. Dr. Lindsley and his predecessor in this position, Dr. Herbert H. Jasper, have during the past eleven years carried out much fundamental research in this field, particularly as it applies to children's neuropsychiatric problems. It is encouraging that other hospitals in the State are developing facilities for electroencephalography after a period of several years during which such examinations were available to Rhode Island physicians only at the Bradley Home.

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Program . . . 135th Annual Meeting

RHODE ISLAND MEDICAL SOCIETY

May 15 - 16, 1946 ***At the Rhode Island Medical Society Library, Providence***

WEDNESDAY, MAY 15

2:00 P.M. CALL TO ORDER

WELCOME BY PRESIDENT, John F. Kenney, M.D.

RECOGNITION OF DELEGATES FROM OTHER SOCIETIES



George Blumer, M.D.

2:15 P.M. "THE VIRUS TYPE OF INFECTIOUS HEPATITIS"

GEORGE BLUMER, M.D., of Pasadena, California

(David P. Smith Clinical Professor of Medicine, Emeritus, Yale University School of Medicine)

2:45 P.M. "MANAGEMENT OF CONVULSIONS IN CHILDREN"

CHARLES BRADLEY, M.D., of East Providence, R. I.

(Superintendent, Emma Pendleton Bradley Home, East Providence)



3:15 P.M. "SOME FACTORS ON HUMAN REPRODUCTION"

JOHN ROCK, M.D., of Brookline, Mass.

(Visiting Surgeon and Director of the Fertility and Endocrine Clinics at the Free Hospital for Women, Brookline, Massachusetts; Research Assistant in Gynecology and Obstetrics, Harvard Medical School.)

3:45 P. M. INTERMISSION TO VISIT TECHNICAL EXHIBITS



Thomas E. Jones, M.D.

4:10 P.M. "SURGICAL MANAGEMENT OF CARCINOMA OF THE COLON AND RECTUM"

THOMAS E. JONES, M.D., of Cleveland, Ohio

(Surgeon, Cleveland Clinic Foundation Hospital)

4:40 P.M. "GASTRITIS AMONG NAVAL PERSONNEL"

RUSSELL S. BRAY, M.D., of Providence

(Captain, USNR Medical Corps; Senior Medical Officer of Gastrointestinal Service, USN Hospital, Newport, R. I.; Assistant Chief of Medicine and Chief of Gastrointestinal Service, Mobile Hospital 109 (Australia); Senior Medical Officer, Dispensary NABU 4 (Philippine Islands); Chief of Gastrointestinal Service, USN Hospital, Bethesda, Maryland; Assistant Visiting Physician and Gastroenterologist, Rhode Island Hospital)



Russell S. Bray, M.D.

5:10 P.M. TOUR OF THE TECHNICAL EXHIBITS

6:00-7:00 P.M. RECEPTION . . . . . At the Narragansett Hotel

7:00 P.M. DINNER . . . . . At the Narragansett Hotel

(*For Members of the Society and their Guests*)

Presiding: JOHN G. WALSH, M.D., of Providence, *Anniversary Chairman*

9:00 P.M. GREETINGS: HON. JOHN O. PASTORE

Governor of the State of Rhode Island



Joseph Stokes, M.D.

The Charles V. Chapin Oration:

"RECENT STUDIES IN THE PREVENTION OF CERTAIN INFECTIOUS DISEASES"

JOSEPH STOKES, JR., M.D., of Philadelphia

(William H. Bennett Professor of Pediatrics, School of Medicine, University of Pennsylvania)

The Charles V. Chapin Memorial Award:

HON. DENNIS J. ROBERTS

Mayor of the City of Providence

THURSDAY, MAY 16

At the R. I. Medical Society Library



Robert E. Gross, M.D.

10:30 A.M. "SURGICAL TREATMENT FOR CARDIO-VASCULAR ABNORMALITIES"

ROBERT E. GROSS, M.D., of Boston

(Assistant Professor of Surgery, Harvard Medical School; Associate Visiting Surgeon, Children's Hospital, Boston)

11:00 A. M. PANEL DISCUSSION: *"THE RHODE ISLAND HOSPITAL UNIT IN THE CHINA-BURMA-INDIA THEATRE OF WAR"*

Chairman: HERMAN A. LAWSON, M.D., *of Providence*

(Colonel, U. S. Army Medical Reserve Corps; Commanding Officer, 48th Evacuation Hospital (October, 1943-May, 1945); Physician, Department of Medicine, Rhode Island Hospital)

"Medical Experiences"

FRANK B. CUTTS, M.D., of Providence

(Lt. Colonel, U. S. Army Medical Reserve Corps; Assistant Physician, Department of Medicine, and Associate, Department of Cardiology, Rhode Island Hospital)

"Surgical Experiences"

J. MURRAY BEARDSLEY, M.D., of Providence

(Major, U. S. Army Medical Reserve Corps; Associate Physician, Department of Surgery, Rhode Island Hospital)

"Background and Highlights"

IRVING A. BECK, M.D., of Providence

(Major, U. S. Army Medical Reserve Corps; Assistant Physician, Outpatient Department, Department of Medicine, Rhode Island Hospital)

continued on next page

12:00 PRESIDENTIAL ADDRESS: "THE FUTURE OF MEDICINE"



John F. Kenney, M.D.

JOHN F. KENNEY, M.D., of Pawtucket, Rhode Island

(President, Rhode Island Medical Society; Chief, Medical Division and Director of the Laboratory, Memorial Hospital, Pawtucket, R. I.; President, New England Conference, American Association of Industrial Physicians)

12:30 P.M. INSTALLATION OF OFFICERS FOR 1946-1947

LUNCHEON (A buffet lunch will be available to members of the Society in the basement dining room)

2:00 P.M. "THE CONSERVATION OF PULMONARY FUNCTION IN THE TREATMENT OF CHEST CASUALTIES"



David Jennison, M.D.

DAVID JENNISON, M.D., of Boston, Massachusetts

(Chief Surgical Resident, Massachusetts Memorial Hositals, Boston)

2:30 P.M. "SOME LATE CLINICAL MANIFESTATIONS OF CAMPAIGN-ACQUIRED TROPICAL DISEASES"



Marshall N. Fulton, M.D.

MARSHALL N. FULTON, M.D., of Providence

(Formerly Associate in Medicine, Harvard Medical School, and Senior Associate in Medicine, Peter Bent Brigham Hospital, Boston; Chief of Medical Service, Valley Forge General Hospital, October 1942-January 1945; Chief of Medical Service, Ashford General Hospital, January 1945-January 1946)

3:00 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

3:30 P.M. "THE HYDRATION AND NUTRITION OF DEHYDRATED PATIENTS DEMANDING PARENTERAL THERAPY"

ALLAN BUTLER, M.D., of Brookline, Massachusetts

(Associate Professor of Pediatrics, Harvard Medical School; Chief of Children's Medical Service, Massachusetts General Hospital.)

4:00 P.M. "MEDICAL EFFECTS OF THE ATOMIC BOMBINGS"

COLONEL ASHLEY W. OUGHTERSON, MC, *of New York City*

(Chairman, Joint Commission for Investigating the Medical Effects of the Atomic Bombings in Japan; Executive Vice President and Medical and Scientific Director, American Cancer Society.)

ALLIED MEETINGS

WEDNESDAY, MAY 15

At the R. I. Medical Society Library

THE RHODE ISLAND ASSOCIATION OF MEDICAL RECORD LIBRARIANS

Presiding: Miss Elizabeth Bingham, R.R.L., *President*

10:30 A.M. BUSINESS MEETING

11:30 A.M. "EVOLUTION OF MEDICAL RECORDS"—Henry B. Moor, M.D.
Chief of the Surgical Division, The Memorial Hospital, Pawtucket

12:00 M. "THE MEDICAL AUDIT"—Henry S. Joyce, M.D.
Assistant Superintendent, The Rhode Island Hospital

THE RHODE ISLAND MEDICAL SOCIAL WORKERS

Presiding: Miss Hope L. Joslin, *Chairman*

1:00 P.M. "THE EXPANDED FEDERAL-STATE VOCATIONAL REHABILITATION PROGRAM"

Charles L. Newberry, M.D. of Washington, D. C.

(Surgeon(R) U. S. Public Health Service; Assistant Medical Officer, Office of Vocational Rehabilitation, Washington, D. C.)

Exhibitors at the

135th ANNUAL MEETING OF THE RHODE ISLAND MEDICAL SOCIETY

Space	
1	Winthrop Chemical Company
2	Buffington's, Inc.
3	Blanding & Blanding
4	Spencer, Inc.
5 & 6	Burroughs Wellcome Company
7	Nutrition Research Laboratories
8	Sharp & Dohme, Inc.
9	Mead Johnson & Company
10	Coca-Cola Bottling Company of R. I.
11	The Claflin Company
12	Doho Chemical Manufacturing Co., Inc.
13	Boss & Seiffert Company
14	White Laboratories
15	The Borden Company

Space	
16	Eli Lilly & Company, Inc.
17	Philip Morris & Company
18	Davies, Rose & Company, Ltd.
19	Smith, Kline & French Laboratories
20	Owens-Corning Fiberglas Corporation
21	Alkalol Company
22	Lederle Laboratories
23	L. & B. Reiner Company
24	Bilhuber-Knoll Corporation
25	U. S. Vitamin Corporation
26	C. B. Fleet Company, Inc.
27	Schering Corporation
28	C. V. Mosby Company
29	Smith-Holden, Inc.

MAKE YOUR RESERVATION *BEFORE* MAY 6 FOR THE DINNER-MEETING AT THE NARRAGANSETT HOTEL ON MAY 15 AT WHICH THE CHAPIN ORATION WILL BE GIVEN. RESERVATIONS SHOULD BE MADE THROUGH THE SOCIETY'S EXECUTIVE OFFICE.

CHANGES PROPOSED IN CASH SICKNESS COMPENSATION LAW OF PARTICULAR INTEREST TO PHYSICIANS

(As passed by the House of Representatives of the Rhode Island General Assembly on March 29, and referred to the Committee on Labor of the Senate)

"Sec. 2.

"(13) *'Sickness.'* An individual shall be deemed to be sick in any week in which, because of his physical or mental condition, he is unable to perform his regular or customary work; PROVIDED, however, that an individual shall be deemed to be sick in any week when such sickness prevents him from being able to perform his regular services, even though such employee is paid his regular wages or parts thereof by his employer for such absence due to sickness."

"Sec. 5.

"(4) *Duration of Benefits.*

"No individual shall be deemed eligible for benefits for a period of excess of 15 weeks for unemployment due to sickness resulting from pregnancy, whether such sickness be prenatal, postnatal, or a combination of both; PROVIDED, HOWEVER, that the aforesaid limitations shall not apply to unusual complications arising as a result of childbirth."

"Section 5

"(b) *Appeal to Board of Review.* The governor shall appoint three persons, not more than two of whom shall be of the same political party to act as a board of appeals, one of whom shall be a representative of employees, one shall be a representative of the public, and one shall be a representative of the medical profession. Members of said board shall serve at the pleasure of the governor and shall be compensated for their service as members of said board at the rate of $25.00 for each day on which said board shall hear appeals in accordance with the provisions of this act.

"Any benefit claimant aggrieved by any decision of the unemployment compensation board, other than a unanimous decision, may within ten days appeal to the board of review. Said board of review may, after such reasonable notice to the parties as it may by regulation prescribe, and after an opportunity for a hearing, set aside or confirm any decision of the unemployment compensation board. The board of review shall promptly notify the interested parties of its findings and decisions.

"(c) *Exhausting of administrative remedies.* A request by any interested party for further appeal, from a unanimous decision of the unemployment compensation board, as provided in this section, in the manner prescribed by the rules of said board, shall be deemed to exhaust the administrative remedies referred to in section 9 (8) of this act; and a refusal by the board to permit further appeal and written notice thereof, shall be deemed a final decision of the board from which appeals may be taken to the courts. A final decision of the board of review shall also be deemed to exhaust the administrative remedies referred to in section 9 (8) of this act, and shall be deemed a final decision from which appeals may be taken to the courts.

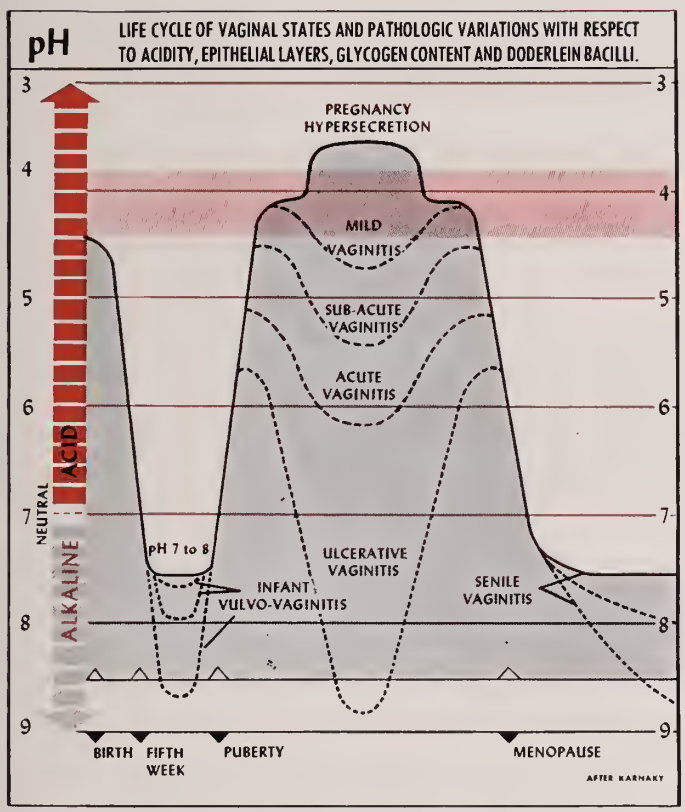
"***."

"Sec. 17. The board shall undertake an educational publicity program designed to safeguard the fund created by this act. The board shall solicit the cooperation and assistance of labor, industry, and the public generally, in effecting such program. In the exercise of its authority hereunder, the board shall give publicity to the need for accident prevention, and the preservation of health; it shall publicize the need for industrial employment to provide the best available safeguards for workers, as well as appropriate sanitary facilities. It shall also publicize the potential results of malingering.

"Sec. 18. A committee to be known as the cash sickness advisory committee is hereby created to consist of seven members, five of whom are to be selected by the governor and to serve at his pleasure; of said five members, three shall be representatives of labor and two shall be representatives of the general public; of the two representatives of the public, one shall be a member of the medical profession. The chairman of the labor committee of the senate and the chairman of the labor committee of the house of representatives shall also be members of said committee.

"Said committee shall meet monthly and shall review the activities of the administration of the cash sickness benefit fund. Said committee shall file a quarterly report with the unemployment compensation board and shall report annually to the governor, which said report shall contain recommendations as to the administration, management and operation of the fund. The said committee shall also submit annually to the governor its recommendations as to any proposed amendments to the cash sickness act."

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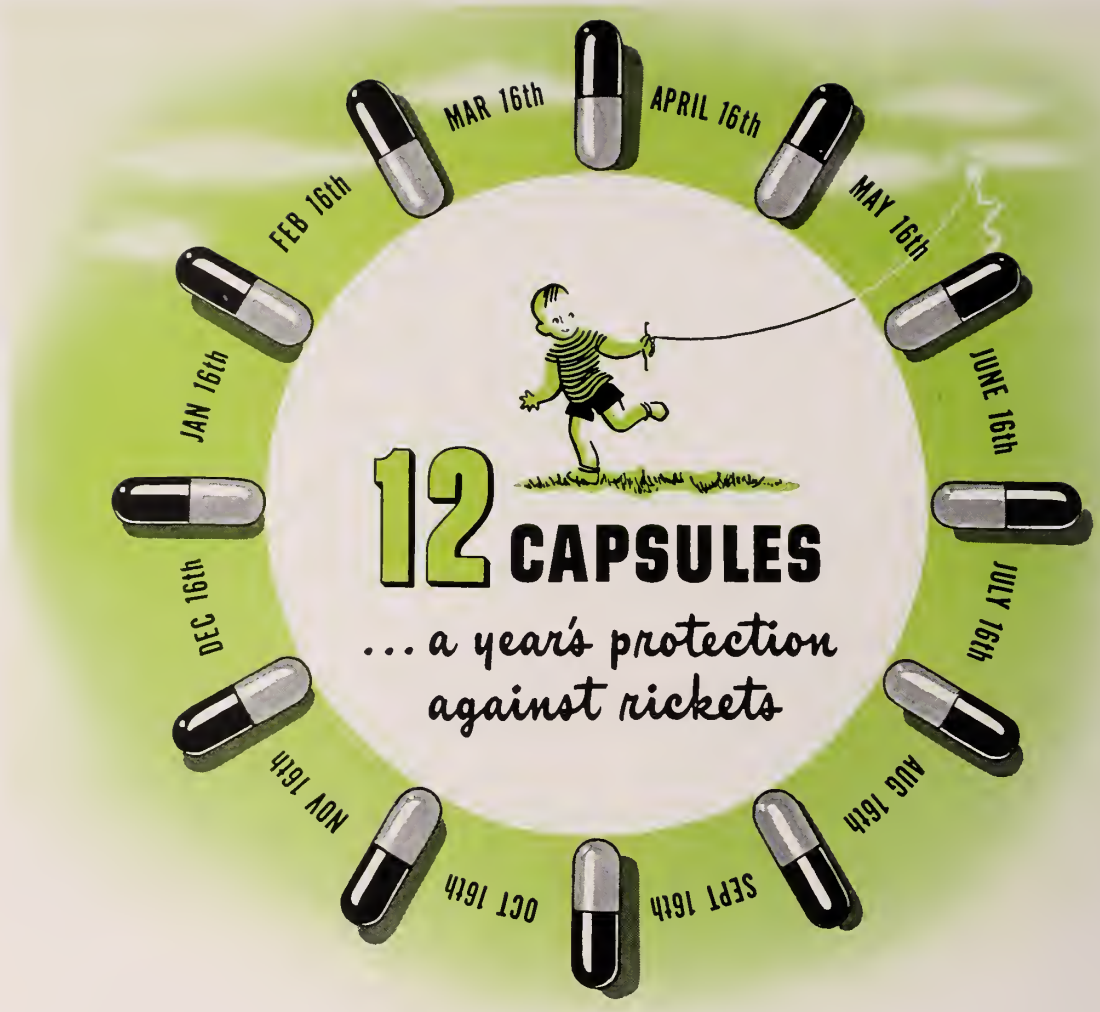
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REFERENCES:

Rambar, A. C., Hardy, L. M. and Fishbein, W. I.: J. Ped. 23:31-38 (July) 1943

Wolf, I. J.: J. Ped., 22:707-718 (June) 1943

Wolf, I. J.: J. Ped. 23:396-417 (April) 1943

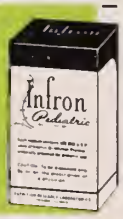
Wolf, I. J.: J. Med. Soc. New Jersey, 38:436 (Sept.) 1941

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HELEN M. BLAISDELL, R.N., *Vice President* WILLIAM SLEIGHT, *Treasurer*
ARTHUR H. RUGGLES, M.D., *Editor*

NEW ENGLAND HOSPITAL ASSEMBLY HOLDS ANNUAL CONVENTION

THE New England Hospital Assembly conducted its first Post-War meeting on March 11, 12 and 13 at the Hotel Statler in Boston. The President of the Assembly this year was Mr. Carl A. Lindblad, Director of the Homeopathic Hospital in Providence.

The Assembly covers five hundred and seventy hospitals in the six New England States and as this was the first Post-War meeting, the attendance was the largest in the history of the Association. The registration exceeded twenty-five hundred.

Practically all Rhode Island hospitals were well represented not only by Directors and heads of Departments, but also by various personnel in the detailed operation of Hospitals.

An innovation this year consisted of fourteen sectional meetings devoted to departmental matters and affording excellent opportunity for guidance and information relative to specific departments.

The opening General Session on Monday morning covered Employee Relations. Under this heading present day wages and hours and working conditions were discussed under the leadership of Miss Dorothy A. Hehmann, Director of Personnel at the Grace-New Haven Hospital, New Haven, Connecticut. The subject of Pensions and Retirements was under the direction of Mr. Homer Wickenden, Secretary of the National Health and Retirement Association of New York City. This Association has recently organized a Pension Program for non-profit organizations for the purpose of affording a retirement income for hospital and welfare employees. This meeting brought forth considerable interest and questions pertaining to the subjects discussed. The importance of employee relations is one of very definite local interest to our Rhode Island hospitals and the papers read, as well as the discussion following, will make it possible for our Rhode Island Hospitals to intelligently reach conclusions in dealing with the employee problem.

The noon period was utilized in luncheon meetings by all of the State Associations, some of which conducted short business meetings during the luncheon period.

The Monday afternoon program covered such subjects as Admitting Procedures, Laundry Management, Personnel, Trustee Relations, Accounting, Purchasing, and Service Shops. The Sectional meeting on Admitting Procedures was under the direction of Helen M. Blaisdell, R.N., Superintendent of Westerly Hospital, and the Accounting meeting was under the direction of Mr. Leroy P. Cox, Superintendent of the Woonsocket Hospital.

Public Meeting

On Monday evening, a public meeting was held, which was addressed by Major General Paul R. Hawley, Acting Surgeon General, Veterans Administration, who was introduced by Brigadier General Elliott C. Cutler, M.D., Chief of Staff, Peter Bent Brigham Hospital in Boston, Mass. General Hawley outlined the proposed program of the Veterans Administration and the desire of the administration to secure the cooperation of all local hospitals in the care of returning veterans for service connected disabilities. Under the existing laws, the returning veterans may be cared for in civilian hospitals if convenient for service connected disabilities only and occasionally for emergency conditions that may arise where there would not be sufficient time for the patient to be transferred to a Veterans Hospital. In the case of the female veterans, the local hospitals may, under the law, care for both service and non-service connected disabilities.

It is the desire of the Veterans' Administration, that arrangements be made with all local hospitals for the care of these veterans as the needs arise, and that contracts will be entered into with such hospitals in the very near future.

General Hawley also emphasized that any Veterans Hospitals to be erected would be located in

continued on page 290

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N. E. HOSPITAL ASSEMBLY

concluded from previous page

urban areas in order that the Veterans Administration might draw from competent local specialists in caring for the veterans, and assuring them of the best possible professional service.

Group Practice in Hospitals

The Tuesday morning general session was utilized in discussing the very important subject of Group Practice and Changing Professional Relationships as applied to hospital care. Dr. Frederick T. Hill, Medical Director of Thayer Hospital, Waterville, Maine, outlined the procedures in his institution and he was followed by Mr. Donald S. Smith, Superintendent of Mary Hitchcock Memorial Hospital, connected with Dartmouth College in Hanover, New Hampshire. The meeting was also addressed by Dr. Jean A. Curran, Dean of the Long Island College of Medicine, Brooklyn, New York. There is a very definite trend toward Group Practice, especially within the hospitals, in order to assure the patient of the best possible professional advice and service. The speakers, who have had considerable experience with this type of Group Practice, were enthusiastic in their recommendations and no doubt, serious consideration will be given this method of care by the general hospitals.

Meeting on Nursing Procedures

The meeting covering Nursing was in charge of Mr. Oliver G. Pratt, Executive Director of the Rhode Island Hospital and afforded an opportunity for a thorough discussion of nursing problems. Again, on Tuesday afternoon, a series of Sectional Meetings included Dietitians, Medical Record Problems, Credits and Collections, Volunteer Service, Public Relations, Nurse Anaesthetists and Medical Social Service.

Dinner Meeting

The meeting on Tuesday evening was highlighted by the address of Dr. Karl T. Compton, President of Massachusetts Institute of Technology, and although very technical in character, Dr. Compton predicts that the use of scientific knowledge will more and more indicate its value to the medical and allied professions. Dr. Compton indicated that the scientists at the Massachusetts Institute of Technology were working very closely with Harvard and Tufts Medical Schools in perfecting treatment with X-ray, Radium as well as allied energies and he indicated revolutionary methods of care and treatment in the years ahead.

The general session of Wednesday morning brought out the value of Psychiatry in the General Hospital which was presented by Dr. James M. Cunningham, Director, Bureau of Mental Hygiene, State Department of Health, Hartford, Connecticut. A second speaker for this session was Dr. Fred G. Carter, Superintendent of St. Luke's Hos-

continued on page 306



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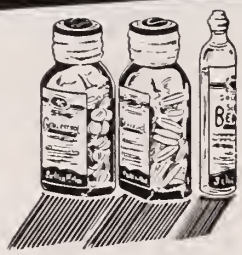
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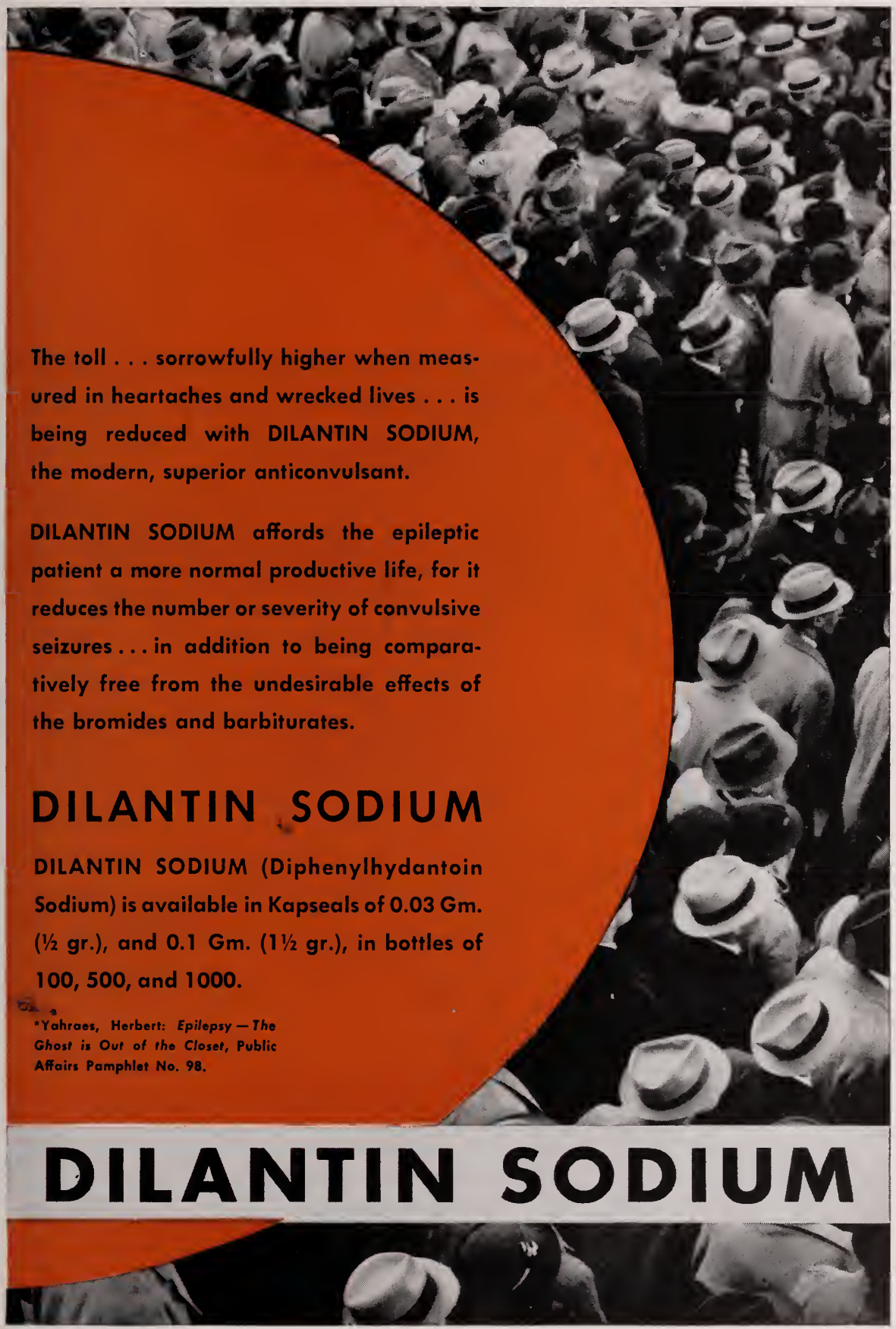
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*Yahraes, Herbert: *Epilepsy — The Ghost is Out of the Closet*, Public Affairs Pamphlet No. 98.

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BY-LAW CHANGES ADOPTED BY THE HOSPITAL SERVICE CORPORATION

(Adopted at Board Meeting, February 20, 1946)

ARTICLE III

Board of Directors

"Section 1. *Number and Qualifications.* The affairs, property and business of the corporation shall be managed by a Board of not less than twenty-one Directors, as fixed from time to time by the members. Directors need not be members of the corporation but must be of full age. There shall be one Director nominated by each contracting hospital from its board of directors or trustees. At least one Director out of every four must be a person authorized to practice medicine in the State of Rhode Island nominated by the Rhode Island Medical Society, and at least two directors must be laymen. The Director of Public Health for the time being of the State of Rhode Island or such other official as may from time to time perform the duties performed by such Director at the time these by-laws are adopted shall be a director or ex-officio.

Section 2. *Election and Term of Office.* The Director shall be elected at each annual meeting of the members of the corporation, and shall hold office until the next succeeding annual meeting and until their successors are elected and qualified.

Section 3. *Filling of Vacancies.* Vacancies in the Board of Directors from any cause may be filled by the remaining Directors at any meeting occurring during the unexpired term of the Director with respect to whom such vacancy exists, by a majority vote of the remaining Directors though less than a quorum, provided, however, that if such vacancy exists as to a Director originally nominated by a Participating Hospital Member or by the Rhode Island Medical Society, such Member or Society, as the case may be, shall nominate the successor.

Section 4. *Powers and Duties.* The Board of Directors shall have and exercise the general management and control of the business and affairs of the corporation and shall have and exercise all of the powers which may be exercised or performed by the corporation under the Statutes, the Articles of Association and the by-laws. In furtherance and not in limitation of the foregoing powers, the Board shall have the power (subject always to the specific provisions of these by-laws) to enter into agreements, incur obligations, borrow money and acquire, invest and dispose of property of the corporation (both real and personal, tangible and intangible) without the assent of the members; to adopt such rules and regulations for the proper management of the affairs of the corporation and the conduct of its meetings as the Board shall deem proper; to elect an Investment Committee and such other committees of such membership, and delegate to them such of its powers and duties, as it may deem necessary or desirable; to remove any office or officers at any time in its discretion and fill any vacancy so caused; and to appoint and discharge agents and employees, define their powers and duties, and fix and determine their compensation. Provided, however, that the Board shall not adopt or amend any medical or surgical fee schedule relating to any non-profit medical-surgical plan except with the prior written approval of the House of Delegates of the Rhode Island Medical Society. Failure of the House of Delegates to approve of

continued on page 298



SURGICAL PLAN AFFIDAVIT FILED

Photo shows Secretary of State, Armand H. Cote, accepting affidavit of the Rhode Island Medical Society as presented by Dr. John F. Kenney, president, to permit the Hospital Service Corporation of Rhode Island to administer the surgical insurance plan. Mr. George Davis (at right), member of the board of directors of Blue Cross, representing the public, watches the signing of the document.

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HOSPITAL CORPORATION BY-LAWS

continued from page 297

any proposed or amended fee schedule within 45 days after written notice thereof from the Board of Directors shall be deemed to constitute approval thereof."

ARTICLE VI

Contracts of Corporation

"Section 1. *Limitation on Contracts.* No Director or officer of the corporation shall have any personal financial interest, direct or indirect, in any contract relating to the business conducted by the corporation or the furnishing of supplies to the corporation, unless authorized by the concurring vote of two-thirds of the full Board of Directors; provided, however, that this section shall not limit the right of a hospital of which a Director or an officer of the corporation may be directly or indirectly interested as a member of its staff or otherwise, *or of a participating physician*, to contract with the corporation to furnish hospital or medical-surgical service to its subscribers.

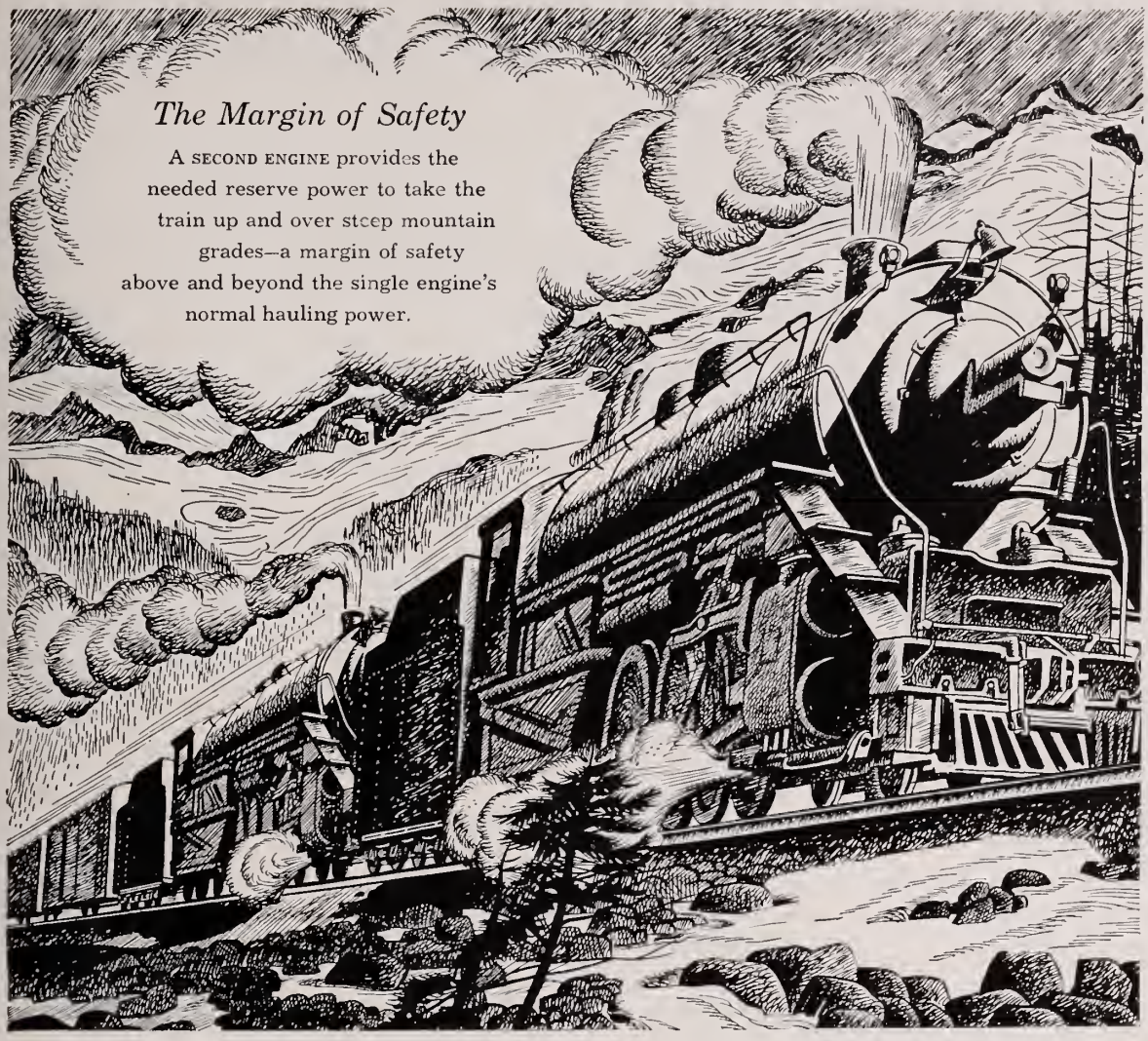
"Section 2. *Contracts for Hospital and Medical-Surgical Service.* Contracts for the rendering of hospital and/or medical-surgical service to subscribers may be made with such eligible hospitals and participating physicians and upon such terms and conditions as the Board of Directors may determine from time to time.

"Section 3. *Subscriber Contracts.* Contracts with subscribers for hospital and/or medical-surgical service shall be in such form and shall be made with such persons as shall be from time to time determined by the Board of Directors."

ARTICLE XII

Amendment of By-Laws

"These by-laws may be amended, added to, altered or repealed, or new by-laws may be adopted by affirmative vote of all of the members of the Board of Directors representing the Participating Hospital Members present at any regular or special meeting and of a majority of the other members of the Board present at such meeting, provided notice that the same is to be considered and acted upon, stating the nature thereof, shall have been included in the notice or waiver of notice of the meeting; and provided further that no amendment of these by-laws reducing the number of the representatives of the Rhode Island Medical Society upon the Board of Directors, or effecting any change whatsoever in the provisions of Sec. 4 of Article III of these by-laws concerning adoption or amendment of the medical or surgical fee schedule, shall be made without the affirmative vote of at least all but one of the members of the Board representing said Society present at such meeting."



Providing a generous reserve of vitamin effectiveness well beyond minimum adult needs, Vi-teens Super Potency vitamin tablets serve as a margin of safety in treating even the most severe cases of vitamin deficiency. Two Vi-teens Super Potency tablets daily assures:

Vitamin B_1 (Thiamin HCL) (2666 U.S.P. Units)	8 Milligrams
Vitamin B_2 (G) (Riboflavin)	4 Milligrams
Niacinamide (Nicotinamide)	30 Milligrams
Pyridoxine (B_6)	2 Milligrams
Vitamin C (1500 U.S.P. Units)	75 Milligrams
Vitamin A	5000 U.S.P. Units
Vitamin D	1000 U.S.P. Units

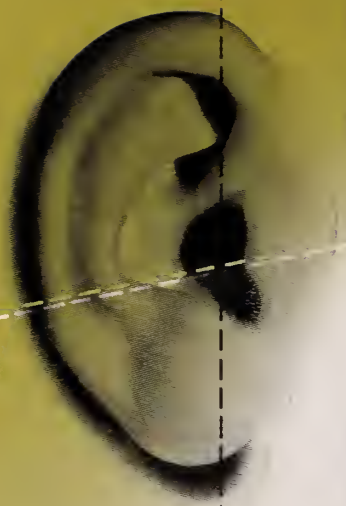
Note especially the close parallel between this Vi-teens Super Potency formula and the needs in extreme cases of avitaminosis where an unusually high dosage of multiple vitamins is indicated... particularly thiamin, riboflavin and pyridoxine. Regular size package of Vi-teens Super Potency vitamin tablets on request.



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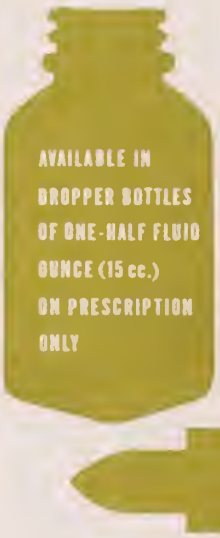
for topical treatment of otologic infections



White's OTOMIDE

A STABLE SULFANILAMIDE-UREA SOLUTION

- **Effective in BOTH acute AND chronic otologic infections.**[1]
- **Potentiated antibacterial potency—because of combined effects of urea with sulfanilamide.**[2]
- **Non-irritating—free from unphysiologic alkalinity.**
- **Effectively analgesic—without impaired sulfonamide activity.**



White's Otomide is a stable, non-irritating solution. Composed of 5% Sulfanilamide, 10% Urea (Carbamide) and 3% anhydrous Chlorobutanol in a specially processed glycerin vehicle of unusually high hygroscopic activity.

Ethically promoted . . . not advertised to the laity.

WHITE LABORATORIES, INC.

Pharmaceutical Manufacturers, Newark 7, N. J.

1. Strakosch, E. A. and Clark, W. G.: Minn. Med., *26*:276-282 (March) 1943.
2. Tsuchiya, H. M., et al.: Proc. Soc. Exper. Biol. and Med., *50*:262-266 (June) 1942.

DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held at the Hearthstone House, East Providence, Rhode Island, on February 27, 1946, at 9 p.m. The meeting was preceded by a dinner given in honor of veteran physicians who are members of the Society.

The meeting was called to order by the President, Dr. William N. Kalcounos. Minutes of the previous meeting were dispensed with. A communication from the Red Cross asking for a donation was read by the Secretary. It was voted to give $25.

Applications for associate membership received from Drs. Arthur B. Cuddy, Reginald Boucher and Raymond T. Stevens were then read by the Secretary.

It was moved and seconded that the Secretary cast one vote for the acceptance of the six new regular members whose applications were presented at the January meeting. These new members are: Drs. Ambrose G. Barry, Arthur A. Helgerson, Edwin F. Lovering, Gordon Marquis, Harold Woodcome and Hrad H. Zooloomian.

Dr. Kalcounos then called upon Dr. J. L. Wheaton to present the report of the nominating committee. His report was as follows:

President: William N. Kalcounos, M.D.
Vice President: Earl J. Mara, M.D.
Treasurer: Laurence A. Senseman, M.D.
Secretary: Kieran W. Hennessey, M.D.
Councilor: J. L. Wheaton, M.D.
Earl F. Kelly, M.D. (alternate)
Delegates: Earl J. Mara, M.D.
Charles L. Farrell, M.D.
Henry Hanley, M.D.
Robert Henry, M.D.
Standing Committee: Earl F. Kelly, M.D.
G. Raymond Fox, M.D.
Joseph H. Doll, M.D.
Armand A. Bertini, M.D.
Edward H. Trainor, M.D.

Following his report Dr. Wheaton welcomed the veteran physicians and presented those present with honorary certificates on behalf of the society. Twenty of the thirty-three veteran physicians were present, namely, Drs. Louis I. Beaudoin, Duncan H. Ferguson, Edward Foster, John Gordon, Francis Hanley, James Healey, Kieran W. Hennessey, Thad Krolicki, Edwin Lovering, Edmond Laurelli, Edward McCaughey, Marden Platt, Raymond E. Stevens, Raymond T. Stevens, Thomas Sheridan, Edward Thompson, Howard Umstead, Frederick Webster, Harold Woodcome, Hrad Zooloomian.

The meeting was adjourned at 10:30 p.m.

Respectfully submitted,

MARY-ELAINE J. ROHR, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The Kent County Medical Society met March 14, 1946, at 4:30 p. m. at the Toll Gate in Westcott.

Dr. Merrill presided.

The minutes of the last meeting were read and recorded as read.

Resolutions of the American Veterans of World War II, "AMVETS" West Warwick Post No. 6 and of the Coventry Post No. 7 of the American Veterans of World War II, both endorsing The Kent County Memoiral Hospital, were received and placed on file.

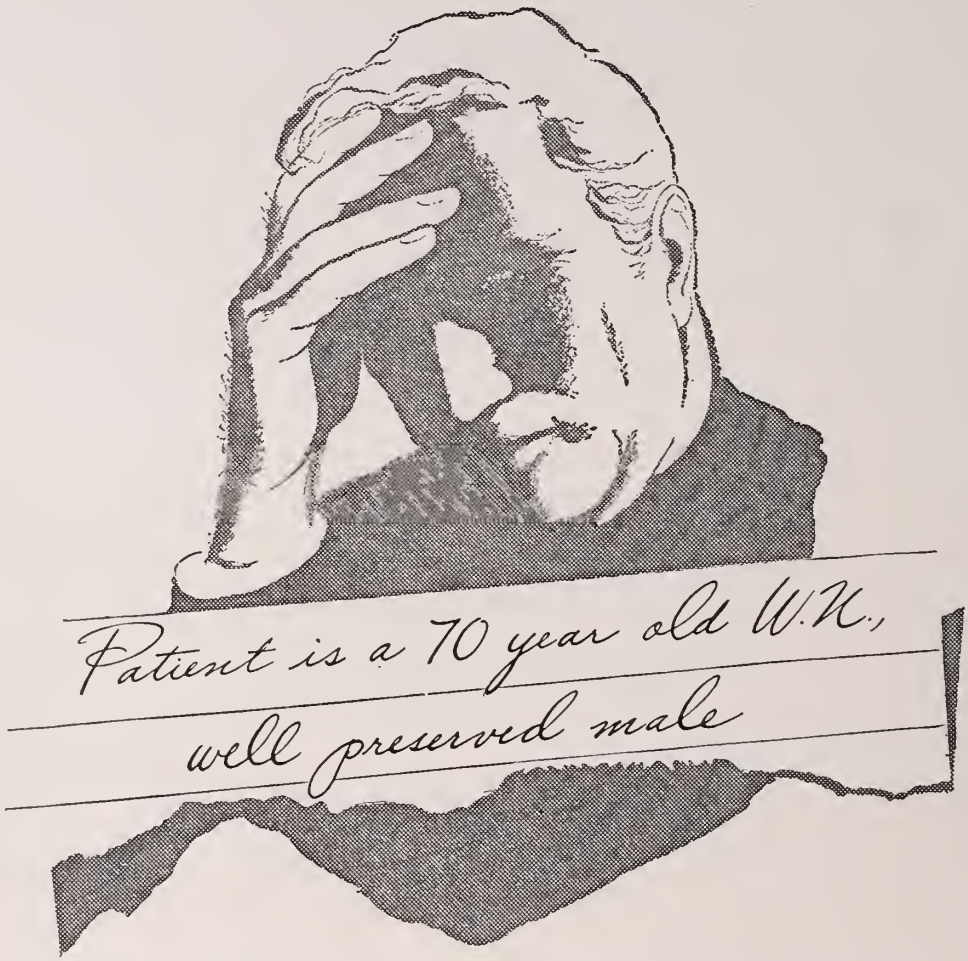
A communication from the Supervisor of Nurses, Mrs. Mulvey, asking whether or not the Tonsil and Adenoid Clinic would be resumed in

continued on page 303



WILLIAM N. KALCOUNOS, M.D.

Re-elected President of the Pawtucket Medical Association for 1946-47



Truly well nourished? Then he'd be outstanding. The hurdles of mastication, digestion and absorption which the aged have to meet frequently threaten nutritive intake. Only by careful inquiry can the vitamin status of elderly patients be determined.

"Severe atypical deficiency disease," states Spies[1], "like other forms of nutritive failure, can be successfully corrected by the application of...four essentials." One of these is administration of the four critical water-soluble vitamins *in high dosage.*

Squibb Basic Formula is the identical formula used by Spies[1,2] and Jolliffe and Smith[3] —based on years of clinical experience.

Each Squibb Basic Formula Vitamin tablet contains: thiamine HCl 10 mg., niacinamide 50 mg., riboflavin 5 mg., ascorbic acid 100 mg.

For our newest professional leaflet with complete information, write on your prescription blank "Nutritive Failure," and mail to Squibb Professional Service Department, 745 Fifth Avenue, New York 22, N. Y.

Basic Formula SQUIBB

1. Spies, Tom D.; Cogswell, Robert C., and Vilter, Carl: J.A.M.A. (Nov. 18) 1944. Spies, Tom D.: Med. Clin. N. Am. 27:273, 1943. 2. Spies, Tom D.: J.A.M.A. 122:911 (July 31) 1943. 3. Jolliffe, Norman, and Smith, James J.: Med. Clin. N. Am. 27:567 (March) 1943.

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

DISTRICT SOCIETY MEETINGS

continued from page 301

West Warwick was discussed. It was moved and adopted that these clinics should be discontinued as there is no need for them at present.

Dr. Young being absent, there was no available report from the Hospital Committee.

Three new members were voted in. They were: Drs. Jean M. Maynard, Joseph C. Kent and Francis D. Lamb.

The nomination of five members to meet with the P. V. Nurses' Association and the Anti-Tuberculosis League, which had been tabled at the last meeting was left today with the President. The following members were selected: Drs. Royal C. Hudson, Peter Erinakes, George B. Farrell, Joseph Harrop and Stanley Davies.

Copies of a communication from the Washington State Medical Society setting forth their Prepayment Medical Plan Program were distributed, as it was too long for reading.

Dr. Dimmitt, representing Dr. Pitts, reported on the Rhode Island Medical Society Prepayment Medical Care Program for the benefit of the County Society members. If accepted by a majority of members of the Rhode Island Medical Society the plan will be supported by the Blue Cross.

The program as it stands is a service plan and not an indemnity plan, sponsoring the clause of minimum fees taking care of the whole charge for the low income group.

A service plan is the better of service or indemnity plans. The indemnity plan would be the same as that of insurance companies.

The Blue Cross is a non-profit organization. Its allocations have covered the full average cost of ward or semi-private accommodations and also paid extra treatments. It has not accepted proprietary hospitals and its directors have worked with no remuneration. It is not interested in an indemnity program.

Discussion returned to local business on fees. A motion was made and seconded that the Secretary advise the welfare departments of Warwick, Coventry and Cranston that the fee schedule of Kent County physicians is as follows:

Office visit	$3.00
House visit	$4.00
Night visit	$5.00 (7 p. m. - 7 a.m.)

Dr. Beardsley was invited to present colored films of his experiences in India and Burma but was unable to do so as the business meeting had been too lengthy.

The meeting was adjourned and dinner was served. There were thirteen members present.

Guest speaker was Dr. Beardsley.

Respectfully submitted,

JEANNETTE E. VIDAL, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, March 4, 1946. The meeting was called to order by President Paul C. Cook at 8:30 p.m.

Dr. Cook called the attention of the membership present to the fact that there is a group taking post graduate refresher courses in Providence in connection with the Pratt Diagnostic Clinic, and he extended the Association's greeting to the men present at the meeting.

The reading of the minutes of the previous meeting of the Association was omitted. The Secretary reported for the Executive Committee as follows:

> At a recent meeting of the Executive Committee four applications for active membership in the Association were reviewed. In addition, one physician, Dr. Marshall Fulton, was reinstated as an active member upon his notification of resumption of practice in this district, and one physician, Dr. John Fracasse, recently returned from military service, was granted a year's leave of absence in order that he may complete a hospital residency.
>
> The Committee voted that all physicians returning from service with the armed forces and applying for membership in the Providence Medical Association shall be exempt from the assessment of dues for the first six months following their election to membership.
>
> The Committee authorized the Committee on Fees to prepare and send to each member of the Association a special questionnaire, and likewise authorized the Committee on a Central Telephone Exchange to prepare and distribute a survey form to assist it in its study.
>
> The Committee voted to recommend two changes in the By-laws to the membership of the Association at its next meeting.

Dr. Cook announced that the Committee consisting of Dr. William O. Rice and Dr. Herbert G. Partridge had submitted a resolution on the death of Dr. John M. Peters, which has been filed with the Secretary. He requested the members present at the meeting to stand for a moment in silent tribute to the memory of Dr. Peters.

The Secretary reported that the Executive Committee recommended for election to active membership in the Providence Medical Association the following men: Drs. Benjamin F. Harley, William J. MacDonald, Henry Miller, Eric F. Turkel.

Dr. William M. Muncy moved the unanimous election of these four applicants. The motion was seconded and passed.

The Secretary reported that the Executive Committee recommended changes in the By-laws of the Association. He read the proposed amendments to the By-Laws.

> Amendment of Section 9, Article I, to read:
>
> "There shall be standing committees as follows: Air Pollution, Advisory Committee to the Curative Workshops, Inc.; Entertainment; Ethics and Deportment; Legislation; Medical Milk Commission; Nursing; Preschool Examination; Reading Room; Scientific Program; Tuberculosis; Water Pollution."

continued on page 305

Summary and Conclusions

1 PROGYNON-B, alpha-estradiol benzoate, an estrogen for intramuscular injection has a prolonged duration of action. 0.33 mg. (2000 R.U.) often controlling menopausal symptoms for 8 to 10 days.

2 Being highly potent fewer injections are required. Cost is, therefore, lower than treatment with other natural estrogens.

3 It produces a remarkable sense of well-being and toxic reactions are practically unknown.

4 "Results . . . lead to the conclusion that alpha-estradiol benzoate is the estrogen of choice."[1]

PROGYNON-B

PROGYNON-B is available in ampules of 1 cc. containing 0.083 mg. (500 R.U.); 0.16 mg. (1000 R.U.); 0.33 mg. (2000 R.U.); 1.0 mg. (6000 R.U.); and 1.66 mg. (10,000 R.U.). In boxes of 3, 5, 6, 50 and 100 ampules.

Trade-Mark PROGYNON-B—Reg. U. S. Pat. Off.

1. Eisfelder, H. W.: J. Clin. Endocrinol. 11:628, 1942.

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DISTRICT SOCIETY MEETINGS

continued from page 303

Also, Amendment of Section 3 of Article II, to read:

"Associate membership shall be available to those physicians who are active members of other district societies and who also wish to be affiliated with this Association, and to those members of this Association who, leaving this State for an indefinite period of time, or permanently, desire to retain an affiliation with this Association.

"Interns and residents serving in any approved hospital in the district of the Providence Medical Association will be accepted as Associate members upon application, and shall be exempt from annual dues."

Dr. Jackvony moved that the Association adopt the amendments. Dr. B. Earl Clarke seconded the motion. On a voice vote the motion was adopted.

Dr. Cook called upon Dr. Frank W. Dimmitt, a member of the State Society's Surgical Insurance Committee, who is one of the seven representatives of the Society on the Board of Directors of the Hospital Service Corporation, to discuss the proposed voluntary insurance program.

Dr. Dimmitt reviewed the work that has been done to date in planning for the non-profit surgical insurance plan, and he discussed the relations between the Rhode Island Medical Society and the Blue Cross Organization. He reported on the several meetings that have been held by the House of Delegates, and he cited the action taken by the House regarding a proposed fee table. He expressed the opinion that concessions must be made by the physicians in working out the details of the program, and he particularly stated that the fee schedule must be drawn to benefit the low income group.

Dr. Cook called upon Dr. Alex M. Burgess to preside at a panel discussion on "Acute Respiratory Diseases" in which Drs. Harold G. Calder, Francis B. Sargent, and Morgan Cutts participated.

Dr. Harold G. Calder discussed the subject from the point of view of the pediatrician. He pointed out the relative infrequence, in his experience, of toxic reactions to sulfonamides in children, although some dangers were obviously still present. With respiratory infections, he felt that otitis media should be constantly looked for, and if present, sulfadiazene should be promptly started. With severe laryngo-tracheo-bronchitis, he felt that penicillin is of great value, and should be promptly used.

Dr. Francis B. Sargent, discussing the subject from the point of view of the otolaryngologist, commented on the probable value of sulfadiazene solution, penicillin, of tyrothrycin locally in early upper respiratory infection. He reviewed the various types of respiratory infections, seen during the past winter.

Dr. Morgan Cutts, presenting the point of view of the internist, pointed out the value of trying to decide whether respiratory infections are viral or bacterial in origin. If sulfonamides are to be used they should be given in adequate dosage. It was pointed out that influenzal vaccine may be of protective value, but its period of protection is brief.

Dr. Burgess, Chairman of the panel group, pointed out that a moderate number of patients with bacterial pneumonia can be distinguished, with great difficulty, from those with viral pneumonia, and in these cases specific treatment is well worth a trial.

Following the presentation, there was a brief period for discussion and questioning from the floor.

Attendance: 97.

The meeting adjourned at 10:10.

Collation was served.

Respectfully submitted,
FRANK B. CUTTS, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The Annual Meeting of the Pawtucket Medical Association was held Wednesday evening, March 20, 1946, at the Biltmore Hotel following a banquet.

Dr. William N. Kalcounos was re-elected President for the ensuing year. Dr. Earl J. Mara was elected Vice-President, Dr. Kieran W. Hennessey, Secretary, and Dr. Lawrence A. Senseman re-elected Treasurer.

The Standing Committee, as follows, was re-elected:

G. Raymond Fox, M.D.
A. A. Bertini, M.D.
Earl F. Kelly, M.D.
Joseph H. Doll, M.D.
Thad. A. Krolicki, M.D.

Elected as Delegates to the Rhode Island Medical Society were:

Charles Farrell, M.D.
Henry Hanley, M.D.
Robert Henry, M. D.
Earl Mara, M.D.

continued on next page



Facsimile of citation awarded by the Pawtucket Medical Association to each of its members serving with the Armed Forces in World War II.

DISTRICT SOCIETY MEETINGS

continued from preceding page

Following the conclusion of the business meeting Dr. Earl Kelly presided as master of ceremonies. Musical selections were offered by Miss Anne Trematozzi accompanied by Miss Louise Windsor.

The Association voted a sum of money to the Children's Heart Association to help send underprivileged children to Camp Westwood, the local Y.M.C.A. camp.

Mr. John E. Farrell, Executive Secretary to the Rhode Island Medical Society, spoke briefly. He lauded the progressive aims of the local medical societies in Rhode Island and stated that they have served as examples for other medical groups throughout the country.

Dr. James L. Wheaton was presented with a scroll, and a pen and pencil set in appreciation of his fifty years of exemplary service to the profession and the community.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D., *Secretary*

N. E. HOSPITAL ASSEMBLY

continued from page 290

pital, Cleveland, Ohio, whose subject covered costs of hospital operation together with increased rates for the care of patients. Dr. Carter stated that with the increasing costs of hospital care, it was his conviction that the daily expense per patient would, within a very short time double that of the pre-war years, this being due to the increased salaries and wages and higher costs for all materials used within the hospitals. The question of how these increased expenses are to be met is one for every hospital to ponder. If the prediction of a one hundred per cent increase over pre-war years is reached, the cost per day for care of patients in the average institution will exceed $12.00 per day, and although many patients can afford to meet their hospital expenses, the institution must more and more depend upon public funds or Blue Cross Plans for meeting their current expenses.

Construction Session

The final meeting of the Assembly was devoted to a round table discussion on construction. The Panel consisted of the leading hospital architects and Hospital Consultants from the larger cities of the New England states.

It was predicted by the architects present that the cost of hospital construction per cubic foot would be double that of pre-war years, and that it is not likely to change for at least the succeeding five years, with the possibility of higher prices continuing from seven to ten years from the present time.

The final business session elected Dr. Arthur H. Ruggles as Trustee from Rhode Island and Miss Helen Blaisdell was continued on the Program Committee. Mr. Carl A. Lindblad will continue on the Board of Trustees as Past-President.

WELCOME HOME

The Rhode Island Medical Society reports the following Rhode Island physicians as honorably released from active duty, most of whom have resumed the private practice of medicine in this State as of April 1. Additional listings will be made each month and members are urged to report promptly upon their return to Rhode Island.

JOSEPH A. BAUTE, M.D., 4547 Post Road, East Greenwich

J. MURRAY BEARDSLEY, M.D., 82 Waterman Street, Providence

ALPHONSE R. CARDI, M.D., 1303 Cranston Street, Cranston 9

PASQUALE J. CELESTINO, M.D., Main Street, Hope Valley

PAUL COHEN, M.D., 99 Main Street, Woonsocket

EDWARD DAMARJIAN, M.D., 972 Broad Street, Providence

JOHN S. DZIOB, M.D., 200 Olney Street, Providence

MARSHALL FULTON, M.D., 124 Waterman Street, Providence

FRANCIS E. HANLEY, M.D., 336 No. Broadway, East Providence

WALDO O. HOEY, M.D., 93 Eddy Street, Providence

LOUIS D. LIPPITT, M.D., 41 Pocasset Avenue, Providence

FRANK B. LITTLEFIELD, M.D., 199 Thayer Street, Providence

CECIL J. METCALF, M.D., 198 Angell Street, Providence

HENRY MILLER, M.D., 180 Wayland Avenue, Providence

FRANCIS NEVITT, M.D., 659 Hope Street, Providence

NATHAN S. RAKATANSKY, M.D., 52 Gladstone Street, Providence

RALPH D. RICHARDSON, M.D., 68 Brown Street, Providence

ERNEST D. THOMPSON, M.D., 199 Thayer Street, Providence



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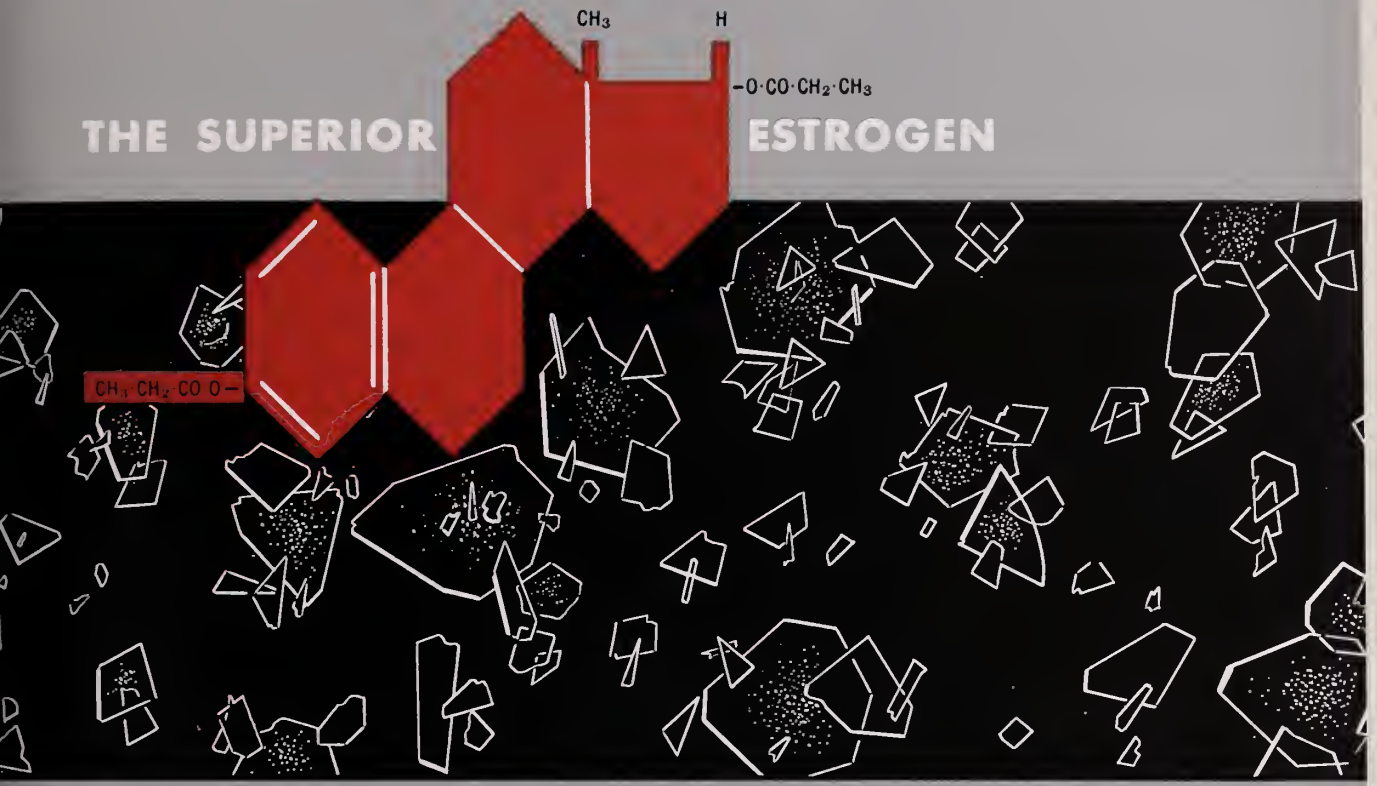
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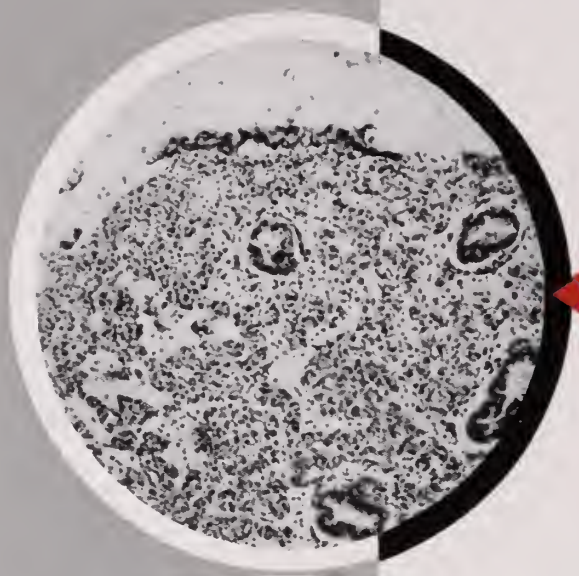
DI-OVOCYLIN

(α-estradiol dipropionate)

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With the development of Di-Ovocylin, Ciba offers the superior estrogen having long-sought advantages of prolonged duration of effect with greatest economy.

CIBA



INFANTILISM:
ENDOMETRIAL
BIOPSY

AMENORRHEA

"While not establishing spontaneous menstrual periads," large dases of estrogenic substances "nevertheless resulted in the appearance af many episades of uterine bleeding, breast development, develapment of pubic and axillary hair and physiological and sacial odjustments."

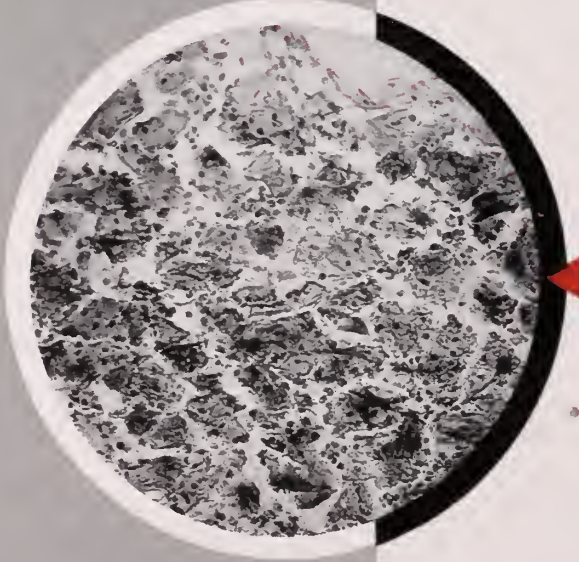
Finkler & Bass: Med. Waman's J., 47: 1, 1940.



DYSMENORRHEA

"The cramps af essential dysmenorrhea can be successfully eliminoted with estrogen when on odequate dose is started eorly enaugh in the cycle. The advantages of using 'estradiol dipropionate' are that a minimum of injections are required ond there are no demonstroble toxic effects."

Sturgis & Meigs: Surg., Gyn., & Obst., 75: 87, 1942



MENOPAUSE:
VAGINAL SMEAR

MENOPAUSE

It is suggested that menopausal potients "should receive injectians of 5 mg. of estradiol dipropianate" . . . "once weekly far three weeks. If this daes not praduce a sotisfactary therapeutic response there is no need ta continue searching for the proper dosoge af estrogens, since this dose is ample for all such coses."

Queries and Minor Notes, J. Am. Med. Assoc., 129 1295, Dec. 29, 1945.

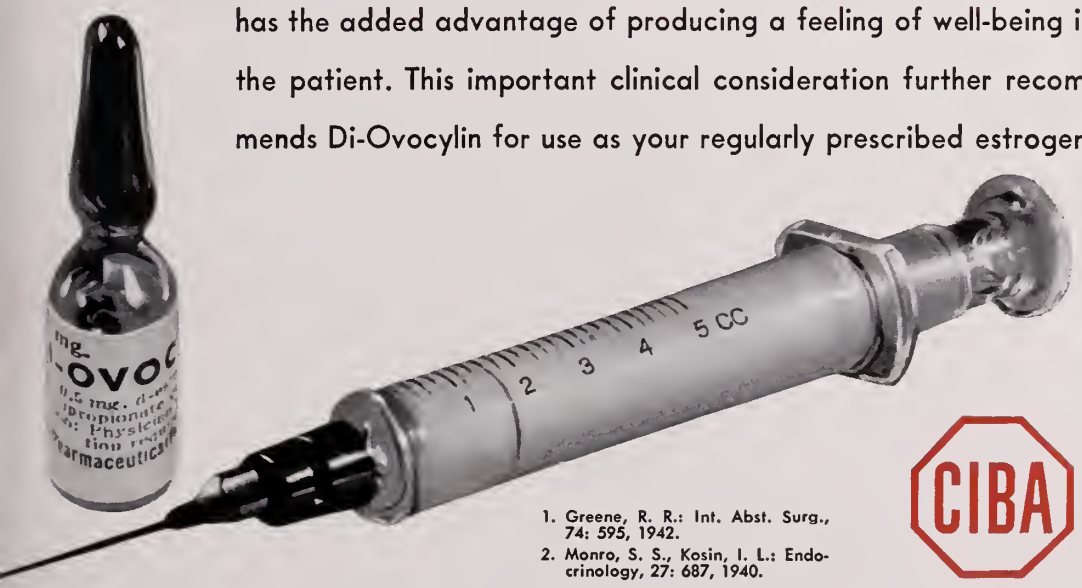
DI-OVOCYLIN

GIVES INCREASED INTENSITY AND PROLONGED DURATION OF EFFECT

Early estrogen therapy was hampered by the short-lived effect of the injection. Increasing doses merely resulted in wastage. Small divided amounts meant inconvenient multiple injections. With the advent of the esterified estrogenic hormone, Di-Ovocylin (estradiol dipropionate), the organism is spared the periodic alternation of hormonal want or abundance, and is supplied a constant, sufficient amount of estrogen. Whereas estrone injections may be required two or three times weekly, a single injection of Di-Ovocylin every fourteen to twenty-one days will control symptoms in the majority of menopausal patients.[1] In potency as well as in duration of effect, Di-Ovocylin offers greatest advantage. In one comparison of the potency of several estrogens, using the oviduct-stimulating power in chicks as criterion, it was shown that estrone had the lowest potency, estradiol and estradiol benzoate were higher, and estradiol dipropionate had highest potency.[2] Make Di-Ovocylin your estrogen of choice for its lasting therapy, easier management of cases, and gratifying economy.

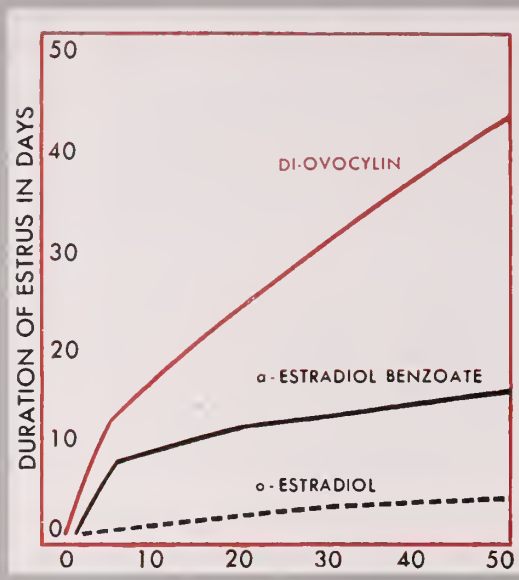
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Di-Ovocylin, being a derivative of a natural estrogenic hormone, has the added advantage of producing a feeling of well-being in the patient. This important clinical consideration further recommends Di-Ovocylin for use as your regularly prescribed estrogen.

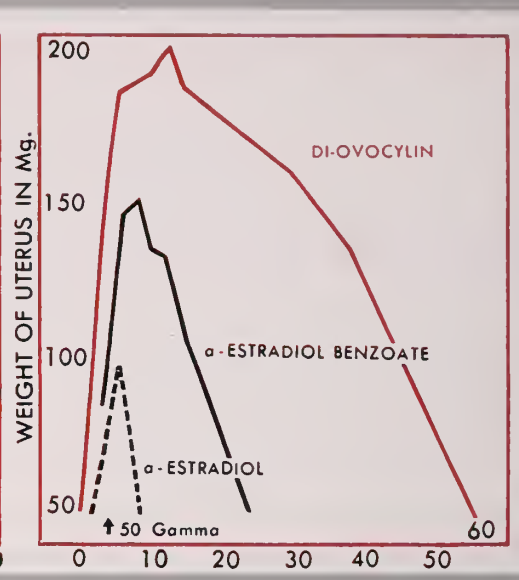


1. Greene, R. R.: Int. Abst. Surg., 74: 595, 1942.
2. Monro, S. S., Kosin, I. L.: Endocrinology, 27: 687, 1940.

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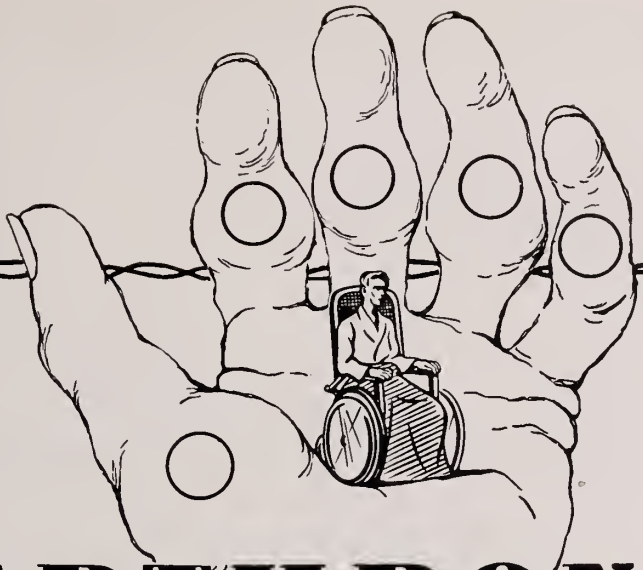
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HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Reports of Special Meetings held February 24, March 3, and March 10

A SPECIAL meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Sunday, February 24, 1946. The following delegates were in attendance:

Abbate, Rocco, M.D.	Fox, A. Henry, M.D.
Callahan, James C., M.D.	Giura, Arcadie, M.D.
Dufresne, Walter J., M.D.	Harrington, Peter F., M.D.
Mara, Earl J., M.D.	Horan, William, M.D.
Sprague, Stanley, M.D.	Jackvony, Albert H., M.D.
Baldridge, Robert, M.D.	Martin, Arthur E., M.D.
Bishop, E. Wade, M.D.	Matteo, Frank I., M.D.
Burgess, Alex. M., M.D.	O'Rourke, Patrick I., M.D.
Buxton, Bertram H., M.D.	Porter, Emery M., M.D.
Clarke, B. Earl, M.D.	Johnson, Linwood, M.D.
Cook, Paul C., M.D.	Pitts, Herman C., M.D.
Cutts, Frank, M.D.	Buffum, William P., M.D.
Davis, William P., M.D.	Cutts, Morgan, M.D.
Famiglietti, Edward V., M.D.	Ashworth, Charles J., M.D.

Also in attendance were Dr. Philip Batchelder, Dr. Frank W. Dimmitt and John E. Farrell, Executive Secretary.

In the absence of the president and the vice-president, Dr. Herman C. Pitts presided. He stated that the purpose of the meeting was to discuss matters incidental to the development of the Voluntary Surgical Insurance Program in Rhode Island. He first called upon Mr. Williamson, legal counsel, engaged by the Society to report on the scope of the Enabling Act.

Mr. Williamson briefly reviewed the terms used in the legislation authorizing the establishment of the non-profit medical service corporation, and he reported on the findings of the legal consultants who had reviewed the law in an effort to determine its scope. The conclusion of the legal firm of Edwards and Angell with whom he is affiliated were as follows:

> "It is our opinion, therefore, that the courts should, and probably would, limit the words 'duly licensed' in the Enabling Act to those who have received a certificate to practice 'medicine and surgery'. This would exclude osteopaths and chiropractors who receive a certificate to practice osteopathy or chiropractic.
>
> "Under the other construction, namely, that the words 'duly licensed' means 'authorized by law', we believe that osteopaths who can qualify under the statute to practice 'any branch of surgery' have a prima facie case that they come within the meaning of this definition. A chiropractor, whose practice is limited to 'minor surgery' and does not permit the prescription of drugs, would in our opinion be excluded therefrom. The case of an osteopath who is authorized to practice only 'minor surgery' is doubtful, but probably he would be excluded also.
>
> "The Illinois legislature has attempted to meet this problem in recent legislation adopting a medical service plan. Subsec. 7, Chap. 32-569, of the Rev'd. Laws of Illinois, 1945, provides as folows:
>
> "'Every physician licensed in Illinois to practice medicine in all its branches, and who is reputable and in good standing, shall be eligible to become a participating physician in the medical service plan corporation operating in the country in which he resides or practices, under such terms and conditions as are imposed on other participating physicians under similar circumstances.' (Italics ours)
>
> "This statute under our laws would, we believe, produce the same result as we have indicated herein.
>
> "As a practical matter, it would seem necessary to the public welfare to provide in the by-laws of such medical service corporation that no physician could participate in such plan without the approval of the Rhode Island Medical Society.

The conclusions advanced by the legal firm were discussed by members of the House, after which the following motion was made:

> The House of Delegates of the Rhode Island Medical Society instructs its elected representatives on the board of the Hospital Service Corporation to request that Corporation to amend its by-laws to provide that only physicians having a certificate to practice medicine and surgery be declared eligible as contracting physicians under the Voluntary Surgical Insurance Plan.

The motion was seconded and unanimously passed.

Dr. Philip Batchelder raised the question of the position of the dentists in view of the fact that dental surgery might be encompassed under the program. Mr. Williamson reported that the Hospital Service Corporation does not plan to have any contracts with dentists at this time.

Dr. Pitts reported the result of the mail ballot to the House of Delegates for the purpose of electing nominees to be submitted to the Hospital Service Corporation for election as representatives of the Society on its Board of Directors. He stated that the following physicians had been nominated and subsequently elected by the Hospital Service Corporation: Dr. Samuel Adelson of Newport, Dr.

continued on next page

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HOUSE OF DELEGATES

continued from preceding page

G. Raymond Fox of Pawtucket, Dr. Frank W. Dimmitt, Dr. Albert H. Jackvony, Dr. Philip Batchelder and Dr. William P. Davis, all of Providence.

There was a discussion of the question of staggering the term of office for the medical representatives on the Board of Directors in accordance with the proposal of the House of Delegates at its last meeting. Dr. Mara moved that the House defer the staggering of the terms of the representatives until the time for the next election of representatives to the Hospital Service Corporation's Board of Directors. The motion was seconded. After discussion Dr. Pitts called for a vote on the question. The motion failed its passage.

Dr. Abbate moved that the staggering of the terms of the representatives of the Society of the Board of Directors of Blue Cross be determined by the President of the Society in order to provide for continuity. The motion was seconded and passed.

Dr. Pitts raised the question of the authority to be given the representatives on the Board of Directors. Dr. Buffum expressed the opinion that the House of Delegates should give these representatives broad powers in order to provide for the success of the program.

Dr. P. F. Harrington moved that the members elected by the Society to serve as representatives on the Board of Directors of Blue Cross be given the power to act for the House of Delegates in matters regarding the Surgical Insurance Plan, and that they also report in writing on their work at each meeting of the House of Delegates. The motion was seconded and passed.

Dr. Pitts opened the discussion regarding the proposed surgical fee schedule for the insurance plan. He stated that copies of the proposed schedule had been sent to each delegate, and he further reported that the table represented the preliminary findings of members of the Society representing the various specialties who had compiled the list on the basis of the Massachusetts and Michigan Medical Service Plans, the Workman's Compensation Schedule used by the Rhode Island Hospital, and the prevailing fees in the community.

Discussion was initiated on the obstetrical and gynecological fee table. Dr. Dufresne moved that the obstetrical fee be set at $50.00 insteal of $40.00 as listed on the proposed schedule. The motion was seconded and passed.

Dr. Baldridge noted an inconsistency in one listing of fees and, therefore, moved that all caruncles

continued on page 315



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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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HOUSE OF DELEGATES

continued from page 312

be listed at a fee of $25.00. The motion was seconded and passed.

Dr. Pitts moved that the fee for the caesarean section be $150.00. The motion was seconded and passed.

Dr. Jackvony moved that the House adopt the obstetrical and gynecological fee schedule as listed on page 1 of the proposed schedule with the three corrections already noted, and he also moved to accept page 2 of the proposed schedule with the exception of the anesthesia fee. The motion was adopted.

There was discussion regarding the fee to be allowed for anesthesia and finally Dr. Harrington moved that the House report to the anesthetists submitting the fee that it is too high for the proposed surgical plan and that the House asks for a reconsideration of these fees. The motion was seconded and passed.

Dr. Pitts suggested that the various specialty groups be asked to consider the fees applicable to their specialties and to report back their decisions to the House of Delegates at the next meeting. He suggested that Dr. Martin check with the orthopedists, Dr. Dimmitt with the eye, ear, nose and throat doctors, Dr. Baldridge with the urologists and Dr. Batchelder with the radiologists. Dr. Batchelder sought information on the question of X-ray both in and out of the hospital. After discussion it was determined that it would be agreeable to have the radiologists recommend what they feel is a fair fee, and it was suggested that a maximum of $15.00 in any one contract might be offered as indemnity towards the total bill.

There was a discussion of fee schedules in other states, and Dr. Burgess, offering his motion as a test to determine the attitude of the House, moved that it adopt the Michigan Fee Schedule as it is now written. The motion was seconded, but on a voice vote was defeated.

Dr. Pitts called for a decision as to when the House might again meet in special session, and it was the consensus that the next meeting should be held on Sunday, March 3, at 11 a.m. at the Medical Library.

The meeting adjourned at 1:30 p.m.

Respectfully submitted,

WILLIAM P. BUFFUM, M.D., *Secretary*

* * *

A special meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Sunday, March 3, 1946. In the absence of the President, the meeting was called to order by Vice-President Joseph H. Ladd at 11 a.m. The following delegates were in attendance:

Rocco Abbate, M.D.
Samuel Adelson, M.D.
Walter J. Dufresne, M.D.
Earl J. Mara, M.D.
Stanley Sprague, M.D.
Robert Baldridge, M.D.
E. Wade Bishop, M.D.
Alex M. Burgess, M.D.
Bertram H. Buxton, M.D.
Harold G. Calder, M.D.
Paul C. Cook, M.D.
Frank Cutts, M.D.
George W. Davis, M.D.
William P. Davis, M.D.
Edward V. Famiglietti, M.D.
William Horan, M.D.
Albert H. Jackvony, M.D.
Arthur E. Martin, M.D.
Frank I. Matteo, M.D.
Patrick I. O'Rourke, M.D.
Emery M. Porter, M.D.
George Waterman, M.D.
Linwood Johnson, M.D.
Herman C. Pitts, M.D.
Joseph H. Ladd, M.D.
William P. Buffum, M.D.
Charles J. Ashworth, M.D.

Also in attendance were the following:

John E. Farrell
Herman P. Grossman, M.D.
Morris Botvin, M.D.
Lee G. Sannella, M.D.
H. Frederick Stephens, M.D.
William M. Muncy, M.D.
John A. Hayward, M.D.
William N. Kalcounos, M.D.
Philip Batchelder, M.D.
Samuel Nathans, M.D.
Cecil J. Metcalf, M.D.

Dr. Ladd stated that the officers of the Society had invited Mr. Stanley H. Saunders, Executive Director of the Hospital Service Corporation, to be

continued on next page

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HOUSE OF DELEGATES

continued from preceding page

present to outline the organizational problems of the Surgical Insurance Program. He invited Mr. Saunders to address the House.

Mr. Saunders reviewed the progress of the Blue Cross organization since its inception in Rhode Island and then discussed its problems in connection with the merchandising of the Surgical Insurance Plan. He stated that it would not be possible for Blue Cross to sell the plan unless the premium rate is one that the public can pay, and he expressed the opinion that one thing in particular will make or break the plan and that is the ability to enroll in sizeable numbers those persons in the lower income groups. He expressed the opinion that if the plan is to be useful it must reach these groups.

Mr. Saunders discussed at length the agreements between the Blue Cross and the Society and stated that the former was very much interested in the fee schedule for if it is not in line with other plans, a higher premium would have to be charged before the program would receive the approval of the insurance commissioner, and a higher premium would make the selling of contracts in any appreciable number a difficult task.

In answer to inquiries from the House Mr. Saunders expressed opposition to any proposal to inflate the fee schedule and then to pro rate the fees on the basis of actual income. He stated that he believed that such a procedure would not be fair to the plan and it would also disillusion physicians who would continue to receive less than the stipulated fee. He expressed the opinion that the physicians should appreciate the task of drafting a fee schedule with the main thought that it is only for those in the low income groups, and for all other persons it is an indemnity schedule.

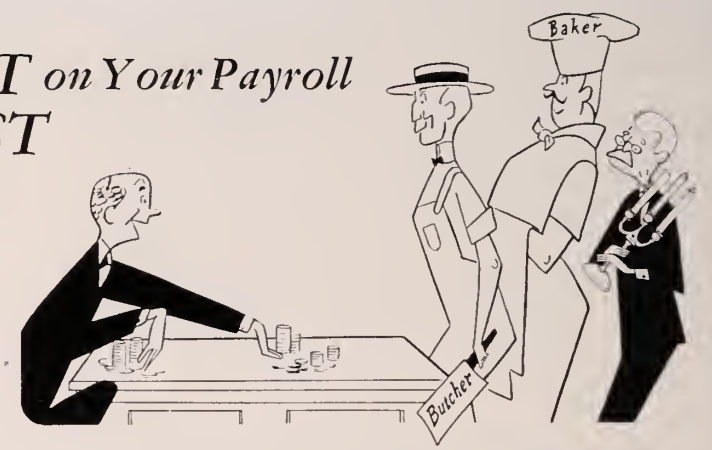
Dr. Ladd reported that the representatives of the Society serving on the Board of Directors of the Blue Cross had had a meeting with the officials of that organization within the week, and he called upon Dr. Dimmitt for a report. Dr. Dimmitt reported as follows:

"Drs. Davis, Adelman, Jackvony, Batchelder, and Dimmitt met with Messrs. MacColl, Davis, Saunders, and Clapp of the Blue Cross, Wednesday afternoon, February 27, 1946. Mr. Saunders and Mr. MacColl gave a resume of the history, development, and present standing of the Blue Cross and pointed out that the stage is set for large-scale enrollment of Blue Cross members under the proposed Surgical Plan.

"It appears that the most important consideration to insure the success of this venture is that the premium

continued on page 319

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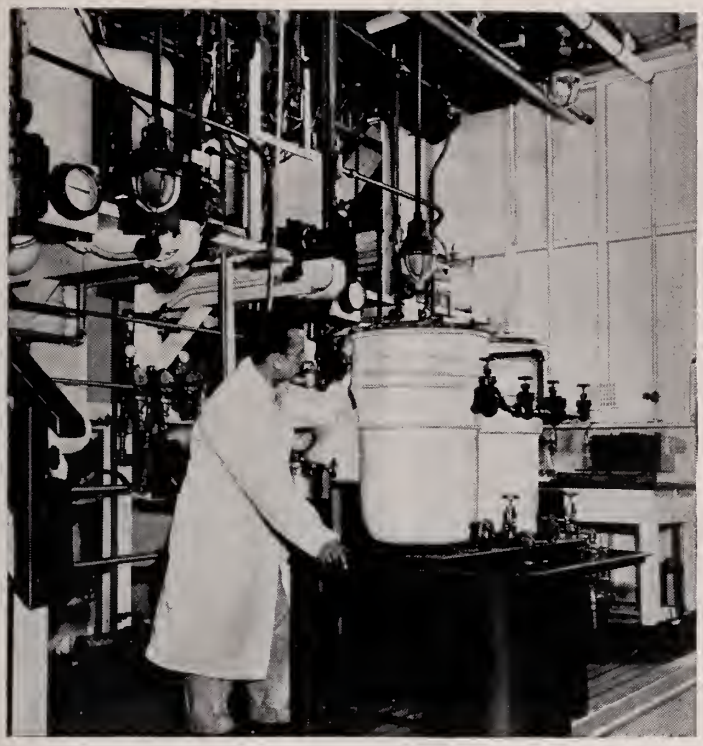
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HOUSE OF DELEGATES

continued from page 316

must be low enough to make the contracts readily saleable in competition with commercial insurance companies. At the present moment two large industrial plants, employing as I recall it about 4800 individuals, are anxiously awaiting the announcement of our plan. They are being urged to purchase contracts for their employees with commercial insurance firms, but are holding off to see what the Blue Cross has to offer.

"Very definitely it will be to our advantage, if our fee schedules can be completed promptly so that the Blue Cross can compute its premium rates and get into the market to sell contracts as soon as possible. It seems that our fee schedule as approved to date and as contemplated is above all others, even that of New York in several instances. It appears to me and perhaps to the other doctors on the Board that we must make some concessions in order to avoid jeopardizing the success of the Plan by forcing the adoption of too high a premium rate.

"Careful analysis shows little foundation for the fear that if we adopted fairly low fees at first, it will be impossible to raise them later. The other view, that it is advisable to begin with very reasonably low fees and raise them later if necessary, seems more proper."

Dr. Ladd called for a general discussion and several members of the House proposed questions which Mr. Saunders answered.

Dr. Adelson of Newport addressed the House to state that in his opinion if the Medical Society is to cooperate with the Blue Cross, the Corporation must change its attitude of feeling that it does not need the surgical plan to augment its services to the people. He cited that the Medical Society is accepting the responsibility in the Surgical Insurance Program as a service to the community and is not seeking any particular advantages or fees to itself. Mr. Saunders replied that he did not wish anyone to miscosstrue the desire of the Blue Cross to cooperate with the Medical profession in working out any of the details of the Program for it is interested in doing a good job for the community.

Dr. Ladd thanked Mr. Saunders in behalf of the House for his kindness in addressing them and answering the inquiries posed.

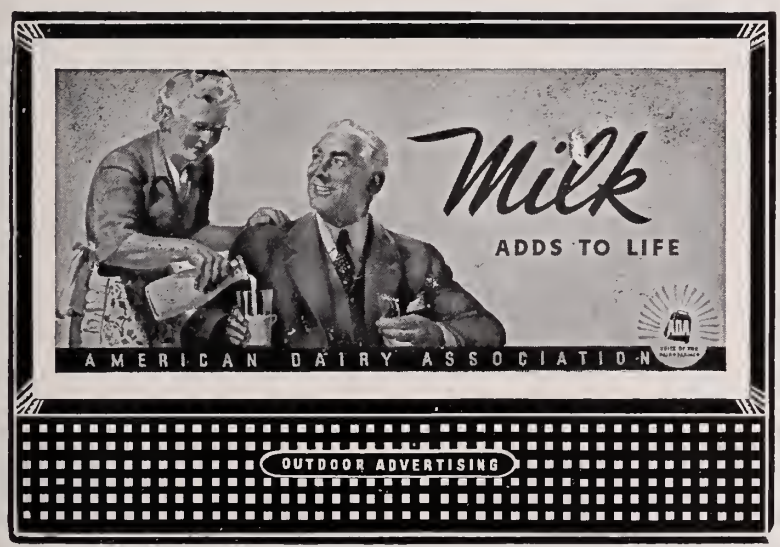
Dr. Ladd called for reports of the Committee chairmen of the various specialty groups who have studied the fee tables for their particular sections. Dr. Arthur E. Martin submitted a report from the orthopedic physicians, Dr. Frank Dimmitt for the eye, ear, nose and throat specialty group, Dr. Batchelder for the radiologists, Dr. Metcalf for the anesthetists, and Dr. Baldridge for the urologists.

Dr. Frank B. Cutts moved:

"That in general the Rhode Island Surgical Insurance Plan have no fee for any operation or procedure which shall exceed the highest fee for this operation or procedure to be found in the schedules of the New York, Massachusetts, Michigan or New Jersey voluntary surgi-

continued on page 321

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HOUSE OF DELEGATES

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cal care plans; and provided further that any exception to this general rule must be hereafter individually considered and the fee approved by a two-thirds majority of the Delegates at a stated meeting."

The motion was seconded.

Dr. Adelson moved to amend the motions to provide that a fee for the assistant be exclusive of the fee paid to the surgeon. The motion was seconded.

Dr. Mara questioned the provision of the requirement for a two-thirds majority of the House and expressed the opinion that the decision should be left to a majority.

After a discussion of the motions before the House Dr. Adelson withdrew his motion and Dr. Dufresne, his seconding of it. Thereupon, Dr. Ladd called for a vote of the motion placed before the House by Dr. Frank Cutts. The motion was adopted.

Dr. William P. Buffum moved that the seven representatives of the Society on the Board of Directors of the Hospital Service Corporation act as a Committee to arrange a tentative fee schedule consistent with the motion just adopted by the House, and that such schedule shall be submitted to the Society. The motion was seconded and passed.

Dr. Ladd asked for an expression of opinion as to when the next meeting of the House should be held. The consensus was that the House should reassemble on Sunday, March 10, at 11 a.m. at the Medical Library.

The meeting adjourned at 1:10 p.m.

Respectfully submitted,

WILLIAM P. BUFFUM, M.D., *Secretary*

* * *

A special meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Sunday, March 10, 1946. The meeting was called to order at 11:05 a.m. by Vice President Joseph H. Ladd in the absence of President John F. Kenney. The following members of the House were in attendance:

Rocco Abbate, M.D.	Albert H. Jackvony, M.D.
Samuel Adelson, M.D.	Arthur E. Martin, M.D.
Earl J. Mara, M.D.	Frank I. Matteo, M.D.
Joseph L. Turner, M.D.	Anthony V. Migliaccio, M.D.
Robert Baldridge, M.D.	Patrick I. O'Rourke, M.D.
Peter Pineo Chase, M.D.	Emery M. Porter, M.D.
Paul C. Cook, M.D.	George Waterman, M.D.
Frank Cutts, M.D.	Robert H. Whitmarsh, M.D.
George W. Davis, M.D.	Linwood Johnson, M.D.
William P. Davis, M.D.	Herman C. Pitts, M.D.
Edward V. Famiglietti, M.D.	Joseph H. Ladd, M.D.
Arcadie Giura, M.D.	Morgan Cutts, M.D.
William Horan, M.D.	Charles J. Ashworth, M.D.

The executive secretary of the Society, Mr. Farrell, reported on a meeting scheduled for the following day by the Governor's Commission to study the R. I. Cash Sickness Compensation Act. He stated that the Society had been asked to send representatives to this hearing to express the views of the profession.

Dr. R. Abbate recommended that appointed delegates be named to represent the Society.

A motion subsequently made that Dr. Herman C. Pitts and Mr. John E. Farrell attend the hearing and make known the views of the Society, and also that any other member of the House of Delegates finding it possible to attend the hearing be urged to do so.

The motion was seconded and passed.

Dr. Ladd stated the special session had been called to continue discussion of the proposed surgical insurance plan. He called for a report from the special committee assigned to the revision of the proposed fee schedule.

Dr. Albert H. Jackvony reported that the Committee had prepared a tentative schedule, copy of which was available for each Delegate. Dr. Dimmitt directed attention to the fact that no action had been taken by the committee relative to additional fees for specialists, and Dr. William P. Davis reminded the House that the committee had made no attempt to establish fees, but had merely checked the Massachusetts, New Jersey, New York, and Michigan voluntary surgical plans' fee tables to make sure that no fee in the proposed Rhode Island table was higher than the maximum for the same operative procedure as listed in these schedules.

Dr. Charles J. Ashworth addressed the House, pointing out that very few of the physicians were acquainted with the many differences existing between a service program and an indemnity program. He reported at length on a complete report published by the Warren County (Pennsylvania) Medical Society citing the dangers of a service type of program. He stated further that he believed all the problems regarding a fee table would be solved if an indemnity plan were adopted, and

He moved that before any action was taken on the adoption of a surgical plan reconsideration be given to the advantages and the disadvantages of both service and indemnity plans.

The motion was seconded.

In the discussion that followed on this motion, Dr. Adelson expressed objection to its adoption, stating that the House should not prolong the study further. Citing the need for consideration of the low income group for the service type of program he urged defeat of the motion. Dr. Pitts supported Dr. Adelson. Dr. Anthony V. Migliaccio briefly reviewed the advantages of the indemnity plan and read the following comment printed in the Warren County (Pennsylvania) Medical Society report:

continued on next page

HOUSE OF DELEGATES

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"It is a very significant fact that most plans formed in the early days (1939 through 1942) violated the directives of the A.M.A. and were service-type plans: California, Colorado, Massachusetts, Michigan, New Jersey, and New York City; whereas plans formed since have, almost without exception, been indemnity type:

Connecticut	North Carolina
Cleveland, Ohio	Central New York
Delaware	Western New York
Kansas City area	Ohio (State)
Minnesota	Oklahoma
Missouri	Texas
Nebraska	Toledo, Ohio
New Hampshire	Utah

Dr. Ashworth stated it would be better that the House take time now to investigate fully the better type of plan than to discover shortcomings in the program at a later date. He maintained that the service type of program would socialize medicine at the state level. He read from the Warren County report as follows:

"Service-type plans, then, are seen to introduce these non-insurance elements:

"1. The intrusion of a third party between patient and physician, and the disruption of the time-honored individual patient-physician relationship.

"2. The dependence by the assured upon a corporation or other organization, rather than upon individual or group practitioners of medicine, to provide adequate medical care.

"3. The control of the profession by the insuring organization, through the introduction of the employer-employee relationship between the organization and the individual practitioner.

"4. A so far invariable reduction of fees below the average, ordinary fees charged the average, ordinary, private patient.

"5. The limitation of the practitioner to the remuneration originally contracted for, no matter what the complications nor the amount of care necessary to be rendered a particular case.

"6. The protection of the insurance company against loss by making the individual doctors agree to shoulder any such.

"7. The substitution of the corporate and contract practice of medicine for the present system of the private, individual practice of medicine."

Dr. Pitts read the following pro and con statements regarding the service vs. indemnity plan as listed by the Blue Cross:

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2. it would be easier	

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HOUSE OF DELEGATES

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Dr. Ladd called for a voice vote on Dr. Ashworth's motion. The vote was given and the Chair ruled the motion adopted. Dr. Pitts called for a show of hands on the vote. The vote was 10 for adoption and 10 opposed.

Dr. William P. Davis called to the attention of the House that the voluntary hospitalization plan is operated on an indemnity basis. After further discussion Dr. Ladd called for a standing vote on the motion. *The vote was 11 for adoption and 12 opposed, and therefore the Chair ruled the motion defeated.*

Dr. Anthony V. Migliaccio

> moved that the House of Delegates take no final action on the problem of insurance until the Medical Society has had an opportunity to express itself; and further, that the House of Delegates carry out the wish of the Society when that wish is made known.

Dr. Mara seconded the motion.

In the discussion of the motion, Dr. Mara pointed out that many physicians were opposed to the planned program because they had but limited knowledge of it, and therefore would object to signing a contract to render the service proposed. He stated that many physicians do not attend the meetings of either the state or their district society and therefore some method must be found to reach them directly that they may be informed. Dr. Johnson of Westerly stated most of the Washington County physicians were in favor of the plan. Dr. Adelson reported that the Newport County Society hopes to have some of the authorities best informed of the program address them at their next meeting. Dr. Mara discussed briefly the question of fees as paid physicians in Pawtucket. Dr. William P. Davis stated he felt definitely that the House should approve or disapprove the plan together with the fee schedule proposed and then place the matter before the entire Society. Dr. Johnson inquired what would be the attitude if a compulsory plan was established by the federal government, and Dr. Migliaccio answered expressing the belief that the federal plan would be better in so far as the personal income of the physician would be concerned. Dr. Whitmarsh expressed favor with the recommendation that effort be made to educate the members of the profession through their district societies regarding the proposed voluntary program of the Society. Dr. Emery M. Porter stated very few physicians know much about the mechanics of the program as the details are not clear. He expressed the belief that the House should settle on the fee schedule, submit it to the Blue Cross, and once rates are set submit the entire proposition to the Society for a decision.

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HOUSE OF DELEGATES

concluded from page 324

Dr. Ladd called for a voice vote on Dr. Migliaccio's motion. The vote was for adoption with no dissenting vote expressed.

Dr. Robert R. Baldridge moved that the benefits to be given the public under the plan now under consideration shall be limited by the four plans studied.

Dr. Migliaccio seconded the motion and read a tabulation of fees for various voluntary surgical plans in the country.

After discussion of the motion Dr. Baldridge withdrew it to allow Dr. Migliaccio to submit a

revised motion that benefits allowed by any Rhode Island surgical plan shall be limited by the benefits in any of the four plans used in preparing the tentative fee schedule, provided this fee schedule is adopted.

The motion was seconded by Dr. Mara.

The motion was discussed. Dr. Adelson cited that only EENT men can do tonsillectomies at Rhode Island Hospital as well as other hospitals, and it would be unfair to deny the right to a patient to consult the doctor of his choice, whether a specialist or not, for the operative procedures to be covered by the proposed plan. Dr. Mara maintained that Blue Cross wants to sell a better offer at a lower price than any other voluntary surgical plan in the country.

Dr. Ladd called for a voice vote on Dr. Migliaccio's motion. The motion was defeated.

Dr. Emery M. Porter moved that the House reconsider its previous action relative to the allowance of $300 for each dependent in establishing the income groups.

The motion was seconded. On a voice vote the motion was adopted.

Dr. Migliaccio moved that the House of Delegates go on record as adopting the fee schedule as presented by the committee.

The motion was seconded. After discussion Dr. Migliaccio withdrew the motion with permission to reintroduce it later in the meeting.

Dr. Dimmitt discussed the question of additional fees for specialists, and reported on the fees established for the tonsillectomy and adenoidectomy. Dr. William P. Davis called attention to the listing in the proposed fee schedule of the letter NL after certain fees, and he explained these fees and the procedures for which the fees were listed, were not found in any of the schedules studied by the committee.

Dr. Waterman cited that additional fees for specialists should be eliminated, and he moved

that the fee schedule should stand as proposed except that no additional fee should be allowed for the services of specialists. The motion was seconded and adopted.

Dr. Anthony V. Migliaccio moved that the Society's representatives on the Blue Cross corporation be authorized to set fees for any procedures not listed by the other plans studied. The motion was seconded and adopted.

Dr. Rocco Abbate moved that the tonsillectomy and adenoidectomy fee be $35 for children under 15 years of age, and $40 for adults. The motion was seconded.

Dr. Ladd called for a standing vote on the motion. The vote was four in favor, and four opposed. (Several did not vote.)

The question was briefly discussed further and a second standing vote was called by the Chair. The vote was six in favor and four opposed, and the motion was declared adopted. (Several did not vote.)

Dr. Adelson

moved that the assistant's fee be set at the same rate as the anesthetist's fee. The motion was seconded and adopted.

Dr. Anthony V. Migliaccio

reintroduced his motion that the House adopt the fee schedule as proposed with the changes as indicated by the House, and with such changes as may be made by the committee in establishing the non-listed (NL) fees indicated in the proposed schedule. The motion was seconded and adopted.

The House adjourned at 2:05 p.m.

Respectfully submitted,

MORGAN CUTTS, M.D., *Assistant Secretary*

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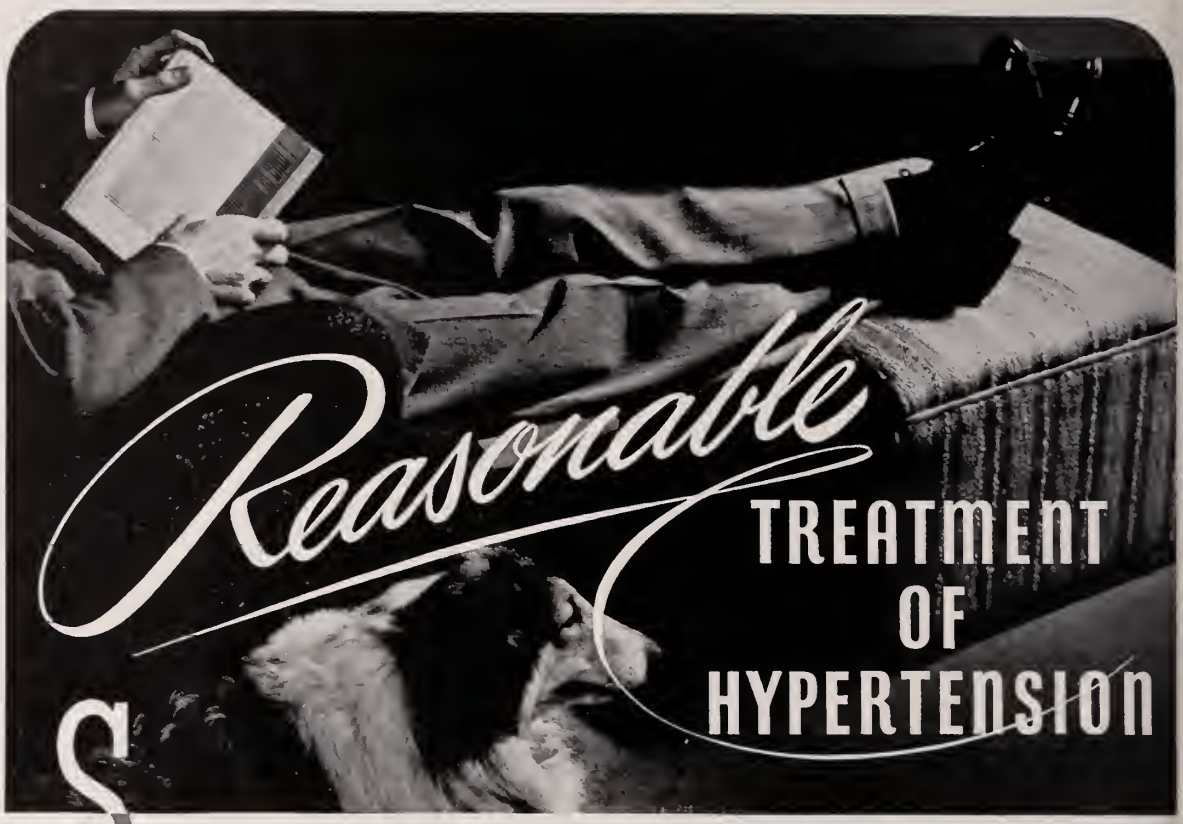
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Volume XXIX, No. 5

Contents Page 339



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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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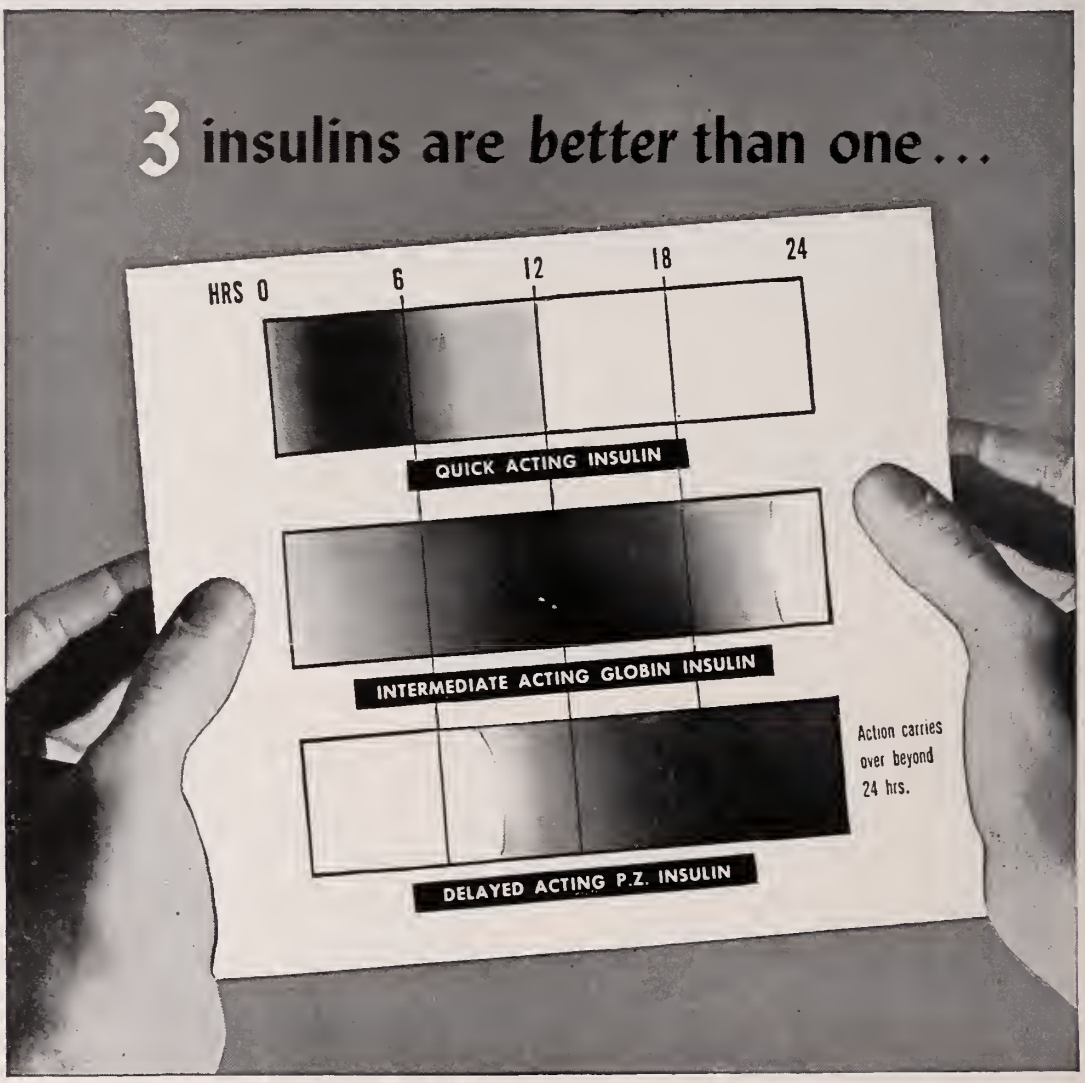
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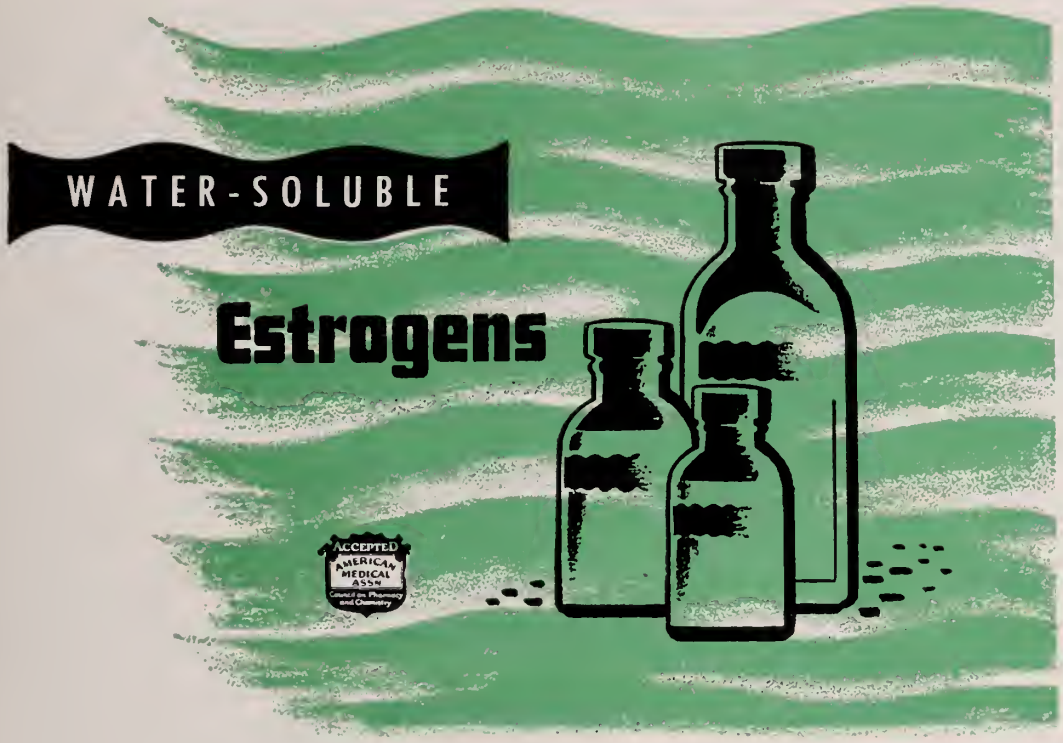
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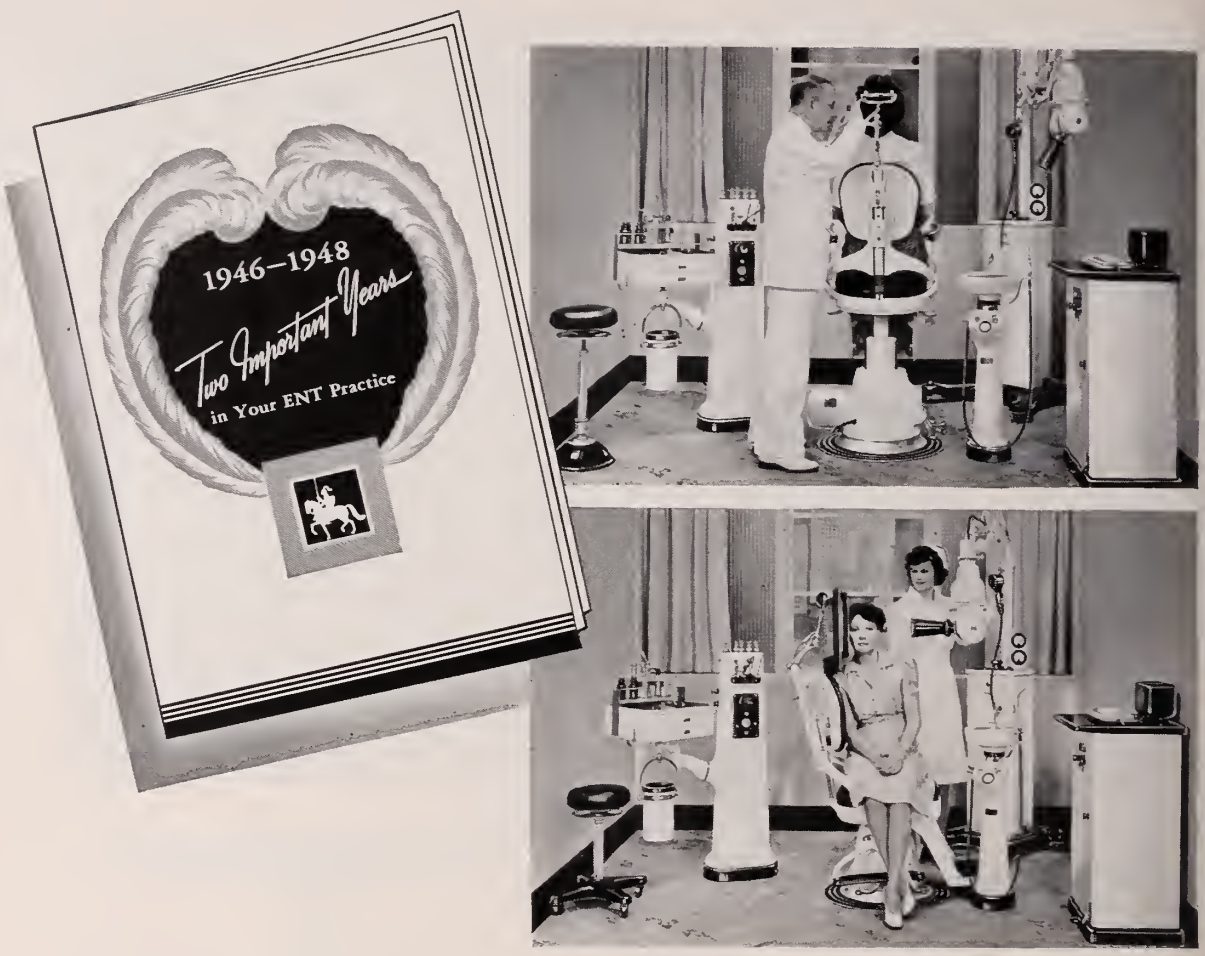
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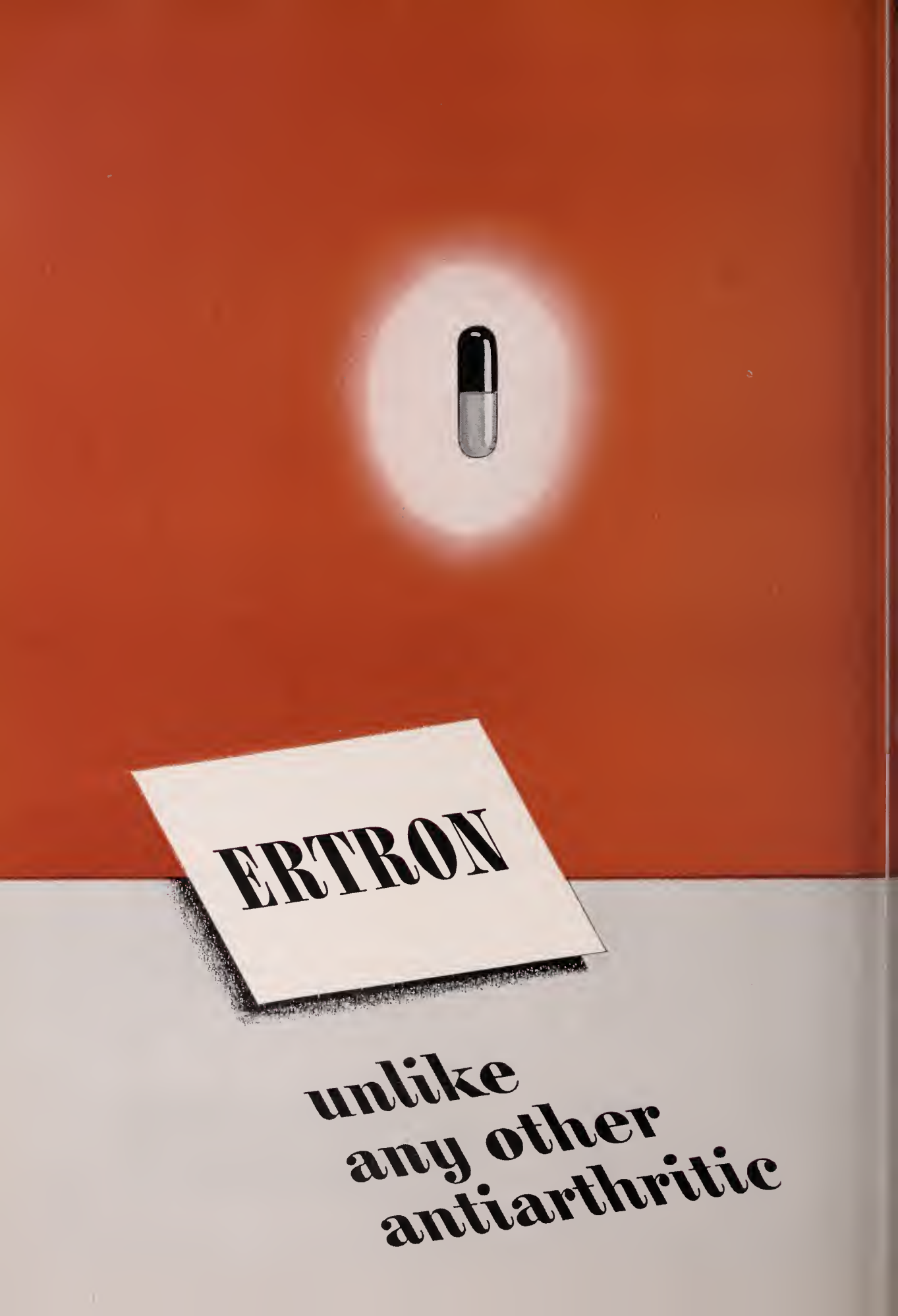
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THESE are busy times for the man of medicine. Deployment of millions of men long in the public service, adjustment of countless dislocations emanating from the war, re-establishment of normal social and economic structures, all have their effect on the health of the people. Harassed by the demands of an avid public, the physician, in the interest of good citizenship if for no other reason, labors throughout the day and much of the night, longingly hoping for the day when the return of more of his colleagues to civilian practice will give him a small measure of relief.

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXIX MAY, 1946 NO. 5

THE WOOD LIGHT

As an Aid to the Diagnosis of Ringworm of the Scalp and other Dermatoses

F. RONCHESE, M.D.

The Author: *Francesco Ronchese, M.D., Dermatologist, Rhode Island and C. V. Chapin Hospital; Diplomate A.B.D.S., Instructor in Dermatology, Boston University.*

A WOOD LAMP is a diagnostic instrument which utilizes ultraviolet light passed through a nickel oxide or similar filter to remove visible light. In a dark room, under the Wood light illumination, many things invisible under ordinary conditions, become visible. It makes certain minerals or printed cloth fluoresce in a peculiar variety of shades. Focused on an old painting it makes the older colors fade almost completely and brings out distinctly the recent restorations. Lipstick marks (fig. 3) in soap-washed faces or laundered table napkins appear clearly as pale yellow spots. Figures or letters on laundered underwear or on forged checks, invisible in ordinary light appear clearly under the Wood light. Food contamination by rodents or insects, impurity in cocoa, flour, etc. are noticeable under the Wood light.

In a dark room, a beam of Wood light focused on the skin makes it appear as a ghastly mixture of increased purplish brown pigmentations over each freckle, scar or enlarged blood vessel, a palette of colors from face powders, creams, lotions, perfumes, lipsticks, etc. Any thickening and scaling of the skin appears pearl-white. The teeth, if natural, appear as fluorescent pearl-white, as does ivory, but, if artificial they are seen as violet-black or lemon-green (fig. 4). A few invisible white hairs appear vividly white.

Although invented in 1903 by the American physicist R. W. Wood, the clinical application of this light in dermatology is comparatively recent as reported by Goodman [1], Gougerot et al.[2], Lewis and Hopper[3], Costello and Luttenberger[4] and others[5].

Ringworm of the Scalp

In dermatology the Wood light is of distinct value in the diagnosis of one of the most stubborn and costly diseases of childhood, ringworm of the scalp.

In a patient of school age (ringworm of the scalp is exceptional in the infant and the adult) the experienced eye, detects ringworm of the scalp easily, from the appearance of the hairless "gray patches", stumps of broken hair, scales, or the hairless, boggy, pustular patches of kerion.

A direct examination will show the spores and micelia. The culture in the appropriate medium will determine the kind of fungus, very important for the treatment to follow.

If such a case is found in an institution where the child has lived in close contact with many other children, he has undoubtedly infected other children due to its contagiousness.

At first, only a few scattered hairs on other children may be infected, patches of alopecia, stumps of broken hair, scales, appearing only several months later. Only then will infected children be sent to a hospital, epilated with x-rays, or otherwise treated, occupying a hospital bed for many months.

When a child with a patch of alopecia, stumps of broken hair, gray scales, etc., is taken into a dark room and a beam of Wood light is focused on his scalp, if his hair are infected with one of the most common type of ringworm, the Microsporons (M. lanosum, M. audouini) that patch will not appear white, gray, yellow or violet, but vivid greenish-white (fig. 1—bottom right). Moreover, while under ordinary light only one or two round hairless spots can be seen, under the Wood light, scattered vivid greenish-white dots can be seen distinctly. These dots are single hairs loaded with spores and micelia, beginning what will later be a spot of scaly alopecia, just as contagious as the hairless areas, but invisible in ordinary light.

If the apparently healthy scalps of all other children exposed are examined in a dark room under the Wood light early infection represented by a few hairs or even a single hair may be detected, and the

continued on page 350



Fig. 1—The black and white ordinary photographs on the top shows a case of alopecia areata (left) and one of ringworm of the scalp (right) from Microsporon audouini, in a colored boy. The case is an advanced one and the difference between the two is clear under ordinary examining conditions. In a dark room under a beam of Wood light the same cases will appear as in the colored illustrations, the alopecia areata (left) a yellowish bald area on a violet background. Ringworm of the scalp (right) appears strikingly different. The areas of alopecia, broken hair and scales are vividly light green. This is the characteristic fluorescence of hair loaded with spores and micelia of the Microsporons, the fungi responsible for the most common type of ringworm of the scalp. The light-green dots scattered on the scalp are the beginning of a new focus of alopecia. In an apparently healthy scalp they are not visible under ordinary examining conditions, but are easily detected under the Wood light.

Fig. 2 (top)—Shows the appearance, under ordinary examining conditions, of a case of tinea versicolor (left) and one of vitiligo (right). Both show a geographic distribution, both show areas of hyperpigmentation and areas of depigmentation. Tinea versicolor in natural color would show yellowish-brown islands corresponding to the areas loaded with Malassezia furfur. In a dark room under a beam of Wood light a doubtful case will become clear. Tinea versicolor (left) will show characteristic powdered-light-golden-yellow islands on a violet background. The mildest case of vitiligo (right) will appear as a ghastly camouflaged implement of war, the depigmented areas becoming vividly white, the normal or hyper-pigmented ones deeply brown-black.



Fig. 3—Feminine osculation marks, invisible after ordinary face washing (right), appear as pale-yellow outlines under the Wood light. Wrist-watch strap dermatitis from the dye of the leather (left), invisible under ordinary circumstances, becomes visible under the Wood light. A helpful sign to prevent an eventually impending dermatitis venenata.

Fig. 4—The teeth at the left under ordinary light appear all alike, natural or artificial. Under the Wood light the natural ones are pearl white, the artificial, violet-black or olive green.

infected hair may be easily plucked out for examination and culture. A cure may even be obtained by the simple removal of that single hair. Without the help of the Wood light the investigator might spend hours searching for infected hairs, removing many of them (perhaps the wrong ones) and give the patient a clean bill of health, while the disease is present but unrecognized.

During and after the treatment, frequent observation will give valuable information as to success, failure, or recurrences.

Pet animals, barber shop instruments upholstered furniture in trains, theatres, etc., can be searched for fluorescent hair, which is potentially infectious.

Infectious lanugo hairs on circinate areas on children's faces or arms, although invisible under ordinary light appear greenish-white under the Wood light, as reported by Costello[6].

Tinea of the scalp *is positively present* when the hair shows the characteristic greenish-white fluorescence under the Wood light, but cannot be ruled out in its absence.

As there is no rose without a thorn nor rule without its exception, this diagnostic apparatus fails in some of the, fortunately, less common forms of ringworm of the scalp, such as tricophyton infections. Prior to direct and cultural examination, the finding of non-fluorescing hair in a clinically typical kerion suggests a resistant infection for which x-ray epilation is indicated. The fluorescing types may be successfully treated without epilation. Discussion on non-fluorescing infected hair can be found in the contributions previously quoted as well as those of Davidson, Gregory and Birt, and Cleveland[7] and of Levin and Behrman[8].

According to Lewis and Hopper[3] fungi fluoresce as follows:

All Microsporons except M. ferrugineum: yellowish-green.

Trichophyton endothrix: dull and bluish.

Achorion schoenleini: greenish (less luminous than the Microsporons).

Malassezia furfur: golden-yellow to dark brown.*

Tinea Versicolor

Tinea versicolor may be distinguished from the leukomelanodermas without extensive dermatologic experience. In general practice however tinea versicolor often is unrecognized. Areas of hyperpigmentation and depigmentation may be dismissed as incurable vitiligo or treated as such with a variety of internal and external remedies of questionable efficacy.

The young female patient with extensive tinea versicolor is ashamed to put on a bathing suit because in spite of free use of soap she appears dirty. However, even in most extensive cases there are always areas free from tinea versicolor. In contrast with these free areas, the characteristic geographic pattern, branny scales, and pinkish-brown color makes tinea versicolor easy to diagnose.

But sometimes one is in doubt, as when a youngster shows some brown round spots of geographic outline, but somewhat obscured by a coating of dirt. The Wood light becomes helpful here, removing all doubt as to what is dirt, vitiligo or tinea versicolor. The geographic patterned areas where the Malassezia furfur has made his habitat, appear as characteristic light golden-yellow powdered islands (fig. 2—bottom left).

In winter when there is less contrast, in vitiligo, between normal and depigmented areas, the whole picture is quite different. The normal or the hyperpigmented areas appear ghastly brown-black, the non-pigmented areas ghastly white, giving to the cutaneous surface the appearance of something camouflaged or of a modernistic painting. (Fig. 2—bottom right).

In such cases a warning must be given. Neurotic patients may be emotionally disturbed by the appearance of their skin, for which reason it may be advisable to cover some patient's eyes during the examination.

Other Dermatoses

In addition to ringworm of the scalp, tinea versicolor and the leukomelanodermas, early stages of macular syphilides, and the light pigmentations, remnants of unnoticed macular syphilides may be detected under the Wood light. Such are good examples of invisible dermatoses.

The one invisible nit left on a blond scalp can be easily located mostly because it appears distinctly egg-shaped.

Invisible effects of Roentgen irradiations can be studied, eventually preventing excess of dosage.

Patients denying having used any medication on their skin can be detected since many ointment bases fluoresce even after the skin has been thoroughly washed. Patches of various colors can be seen in the axillae from deodorants and antiperspiration creams, and in back of the ears and neck from perfume.

Scarred remnants of the so-called "Jericho boils" of the Armenians may sometimes pass unnoticed, but are revealed by the Wood light. The

*According to Radice (La luz de Wood en dermatologia, Revista Argentina de Dermatosifilologia, 29:101, 1945) none of his cases of tinea capitis fluoresced green. He suggests a different kind of fungi as their cause.

Cappelli (Esame della cute alla luce di Wood, Gior. Ital. di Derm e Sifil. 69:308, 1928) 18 years ago, came to the same conclusion. Perhaps all cases were due to trichophitons.

detection of invisible scars may help in personal identification[9] and hidden scars of criminal origin may be discovered.

A patient may complain of slight itching during the summer season on one wrist. Nothing is noticeable on ordinary light, but under the Wood light, a yellow band patterned from the patient's wrist-watch leather strap, (fig. 3) will indicate a stain of the skin from the dye of the leather. It may be a warning of impending dermatitis venenata which may be prevented by advising against further use of the strap.

Roffo and Roffo[10] studied the senile keratoses under the Wood light. According to these authors the more precancerous the keratoses, the more they fluoresce white because of their higher cholesterol content. If confirmed, these observations will be of importance in dermatology.

All hyperkeratotic conditions like warts, calluses, lichen verrucosus, keratosis pilaris, ichthyosis, psoriasis, false tinea amiantacea (seborrhea sicca), fluoresce vividly white, as do the nails. Molluscum contagiosum does not fluoresce except for the umbellication. Xanthoma and xanthelasma palbebrarum consisting entirely of cholesterol do not fluoresce, but appear dark-brown like freckles, or other hyperpigmented spots since there is no hyperkeratosis.

Smooth senile keratoses of the lentigo type (the ones known to the layman as liver spots) are very dark under the Wood light. I recently saw a woman, sixty years of age with a single patch of smooth senile keratosis of the type just mentioned, on her face. For the preceding two weeks the center had appeared yellowish red as if painted with mercurochrome or tincture of merthiolate. She stated that no medication whatsoever had been applied to the area. I would not have paid much attention to the discoloration if the patient had not been in a state of great nervousness because of fear of cancer. Examined under the Wood light, remnants of lipstick appeared on the lips. They were the same color as the center of the keratosis. The problem was solved and the patient's peace of mind restored.

In keratoderma punctatum, an uncommon type of keratoderma palmaris et plantaris, with a keratin defect, the punched out defective areas are darker under the Wood light. In mosaic warts, a common occurrence on the soles, with a keratin excess, the rough, keratin excessive areas are whiter than the rest of the sole.

Gougerot et al.[2] say that there is no distinction under the Wood light between lichen planus of the mouth and leukoplakia. Costello and Luttenberger[4] report that lichen planus does not fluoresce, but keratinized areas of leukoplakia fluoresce brilliantly. Gougerot and Patte[11] observed basal and squamous cell epitheliomas under the Wood light. The basal (non keratinizing) type does not show any peculiarity to distinguish it from other tumors. The squamous (keratinizing) variety shows no particular characteristics before the stage of ulceration. When ulcerated, it fluoresces as intensely red, as an incandescent lamp, or live coal. This red fluorescence is only on the surface. The deeper areas of surgically excised lesions fluoresce greenish-white.

Gougerot and Patte[11] exclude the possibility that red fluorescence is due to dental tartar (which fluoresces pink-red) because of finding it in ulcerated squamous cell carcinomas outside of the oral cavity. Hematoporphyrin-producing bacteria are suggested as a possible cause.

A Wood light is an essential part of the dermatological armamentarium. With the spread of interest in dermatology among pediatricians[12] the Wood light will doubtless become part of the pediatric armamentarium too. The public health worker and general practitioner may also find it useful.

Summary

The Wood light as a diagnostic instrument in dermatologic practice is described. Because of its power of exciting characteristic fluorescence in certain lesions indistinguishable to the human eye under ordinary illumination it is valuable in the detection of many dermatoses, particularly early cases of ringworm of the scalp and tinea versicolor.

Several Wood light apparatuses are available. According to Davis[13] a Wood light setup can be made in England at the cost of 25 shillings.

Corning Glass Works makes the glass special filter.

Hanovia has adapted it to its water cooled lamp.

Westinghouse makes a black unit using a mercury vapor Wood filter bulb. Strobilite of New York, Ultraviolet Products of Los Angelos and Black Light Products of Chicago, make Wood light projector lamps.

*Hand colored photographs by Marion Blake.

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ACUTE RESPIRATORY DISEASES

A Panel Discussion given before the Providence Medical Association at its meeting at the R. I. Medical Society Library on Monday, March 4, 1946

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Introduction by ALEX M. BURGESS, M.D., *of Providence*
Chief, Medical Service, Rhode Island Hospital

WHEN Dr. Paul C. Cook, President of the Providence Medical Association, set a date for this discussion I was impressed with the great importance of the subject and I said that I think this type of discussion should be repeated quite frequently because of the new lights being shed on it year by year. As we all known more time is lost because of upper respiratory infections than any other cause. As evidence, the situation in colleges and schools. So we cannot doubt the importance of the subject. Probably ten years from now we will look back and what we say tonight will seem obsolete as what we said ten years ago would be obsolete now. Bacterial infections and the virus infections about which we know so little are with us all the time and we have to deal with them as best we can.

The plan of the discussion is this. It is absolutely unrehearsed. What we will do is this—to have each man take fifteen minutes to say his say. No one knows what the other will say and we trust that there will be some conflict of opinion and out of it all we can get a good working idea of what to do when confronted by the upper respiratory infections. I trust a number of questions will be answered. While we recognize virus infections as such what is their relationship to bacterial infections? What is the prophylactic benefit if any of a high vitamin diet, bacterial vaccines, new virus vaccines, the prophylactic use of sulfonamides? How should we treat primary atypical pneumonia, should we use penicillin? How long should we use it if it does not work? How long should we use it if it is effective? How about acute follicular tonsillitis? Should we type our pneumococci? How about aerosol penicillin? Those are the things I think you will hear answered in one way or another, perhaps in several ways.

Dr. Harold G. Calder will discuss acute respiratory infections from the point of view of the pediatrician. Dr. Francis B. Sargent will then take up the cudgel for the nose and throat service. Dr. Morgan Cutts will conclude with a presentation of the point of view of the internist.

ACUTE RESPIRATORY DISEASES FROM THE STANDPOINT OF THE PEDIATRICIAN

HAROLD G. CALDER, M.D.
Member of Consulting Staff, Rhode Island Hospital.

THERE is a larger incidence of acute respiratory disease in children than in any other age group so that we have a special interest in this subject. Before talking of the different varieties, I want to comment on sulfonamide and penicillin.

We have found sulfadiazin satisfactory and use it almost entirely. The dose in children is so much smaller in proportion to the kidney function and the resistance of the blood forming organs that it is a much safer drug than in adults. The toxic reactions are so infrequent that we are much less afraid of it than the internists are.

A recent paper (Incidence of Reactions to Sulfonamide Drugs in Infants and Children, Fiak and Smith—The Journal of Pediatrics, January, 1946) has summarized the toxic reactions in 5000 children. Whereas, in the literature generally, the average incidence in patients of all age groups is about 5 per cent, their incidence was less than 1.4 per cent. There were 60 cases of drug fever (25 per cent of them with rashes); 2 cases of neutropenia; 2 cases of hemolytic anemia; and four cases of anurea. In 300 autopsies no significant kidney damage was found. It was found that sulfonamide could be given repeatedly with various sicknesses without any tendency to sensitize to the drug. It is apparently toxic to only a few patients and they are discovered when the drug is first used.

In this series there was no routine use of alkalies. Although debate on this question is still going on, I agree that alkalies are not needed for children and are likely to do as much harm as good. Babies don't tolerate well an excess of socium ions.

This relative safety of sulfadiazine should not blind us to the fact that there is nevertheless some potential danger in its use. There is too great tendency to give it indiscriminately to every child who has a fever; there should be at least a tentative justifying diagnosis. Overdosage should be avoided. If it is going to work, the results are seen promptly, and with the clinical improvement the dose should be reduced. The medication should not be continued long if good results are not obtained.

An adequate fluid intake has always been extremely important in all febrile diseases, and it is especially so when sulfa is being taken. The rectal route is still practical and useful in the home; but parenteral administration in the hospital should be resorted to when necessary.

Although sulfadiazine is still the routine, penicillin has some advantages. It is more effective and less toxic. Because of the greater difficulties of administration and its relative scarcity, it should be reserved for the patients who have had toxic reactions to sulfa; who have not responded promptly to it; and those with the most virulent infections. If the child is sick enough to need penicillin, it should be given intra-muscularly at three-hour intervals. This has been proven reliable. The evidence for peroral use or for a one-shot-a-day is not sufficient for us to rely on them. The inhalation method should be beneficial in bronchial infections. We must guard against using this valuable drug in a careless way; it must not be wasted.

Acute respiratory infections can be caused by viruses, bacteria or both together. In general, the viruses call forth less local inflammatory reaction and less toxicity, while the bacterial infections bring greater pathological changes, more toxicity and an elevation of the white blood count. The virus diseases do not respond to chemotherapy. The diagnosis is not always easy, however, and in case of doubt a trial should be made. Bacterial involvement is so often found complicating virus disease that it may be justified to use a small dose of sulfadiazine prophylactically. There is a difference of opinion on this point, but I do not believe that this is apt to breed a variety of sulfa resistant bacteria; certainly not in a few days.

Time does not permit a full discussion of all the various respiratory diseases, and I shall emphasize only the points that are of importance in pediatrics.

Coryza in infancy is much more troublesome than in older people. The small size of the nasal passages and the baby's ignorance of any way to clear them combine to cause considerable distress. The mother can be taught to apply gentle suction with one demonstration. Nothing more elaborate than a large-sized medicine dropper is required. She should stand behind the baby and keep both her hands firmly against his cheeks so that no injury can be caused by a sudden movement. The modern nosedrops using the new vaso-constricting drugs are especially useful. The old oily drops and silver salts are not to be advised. It is very doubtful if antiseptics are of any value in the nose. The only purpose of the drops is to relieve plugging so that the nose can be cleaned. Sulfodiazine should be given if there is fever and purulent discharge.

Acute otitis-media is almost one of the childhood diseases. The important points are these—The ears should be examined at each visit. Sulfadiazine should be ordered if there is any sign of inflammation. Parenantesis is almost obsolete and is never necessary if the drug is given early enough. Its only purpose is to evacuate thick pus in a neglected case. There can be no question of the great efficiency of sulfadiazine, but it should be continued in reduced doses until the drum membrane is normal. If it is omitted too soon, a flare-up of pain and exudate may be expected. If you remember how many cases of otitis media were complicated by mastoiditis in the old days you will continue to have a healthy respect for the disease and be careful not to lose control. The mastoid operation today is evidence of too long delayed or insufficient treatment.

Another disease of childhood is croup. The common variety which appears at 9 p. m. and clears up in the morning is easily treated with steam, external heat, ipecac or iodine. When the expected improvement fails to materialize, we are dealing with one of the severe form of laryngitis. Continued evidence of obstruction should call for hospitalization and the services of a laryngologist. Diphtheria is uncommon today, but should not be forgotten. In the treatment of acute laryngo-tracheo-bronchitis sulfadiazine is disappointing, but penicillin is definitely of value. Tracheotomy is preferable to intubation when in spite of all treatment the larynx becomes obstructed.

The usual follicular tonsillitis will get well without chemotherapy, but if there is any indication of the infection spreading beyond the tonsils, as shown by redness and glandular enlargement, it should be used. One attack of tonsillitis is not an indication for tonsillectomy, in itself. Gargles, painting and spraying don't do enough good to justify their use in children's throats. Penicillin lozenges are good for the mouth, but useless for the throat.

The sudden onset of lobar pneumonia with high fever, increased respiratory rate and short cough is usually so characteristic that sulfadiazine can be

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given before the signs of consolidation appear. The x-ray will disclose lobar pneumonia long before it can be accurately located clinically and is of particular value when the diagnosis is in doubt. This situation may happen when the presenting symptom is abdominal pain. If rapid improvement does not follow the taking of sulfadiazine, the diagnosis is probably wrong. The pneumonia may be caused by a virus and will yield to nothing but rest and time or there may be a broncho pneumonia which is much more resistant than lobar to sulfa treatment. In any event, the treatment should be changed to penicillin.

Broncho pneumonia is still a serious disease in small infants and is apt to be fatal in spite of any treatment. Penicillin and oxygen and parenteral feeding are too often unavailing in the babies who show extreme toxemia, distended abdomens and early circulatory collapse. It is quite possible the main etiological agent in these cases is a virus.

Finally, I want to comment on that ubiquitous symptom—cough. The public demands some sort of cough medicine when interfering with the cough reflex may be very bad treatment. It is certainly not good to use enough codein to depress it. The various commercial cough mixtures which have been put out are useless as far as I have observed. The cause of the cough should be treated, and enough barbiturate given to insure sleep if necessary. Hydriodic acid is still the only effective expectorant. Tracheitis usually causes the most irritating and persistent coughing and diathermy or x-ray therapy are sometimes required. Penicillin inhalations should be useful in this condition, but there is no convincing evidence as yet. This treatment makes a dramatic appeal to the public and will probably be the cause of considerable wastage of the drug.

UPPER RESPIRATORY INFECTION

FRANCIS B. SARGENT, M.D.
Surgeon-in-Chief, Department of Otorhinolaryngology, Rhode Island Hospital

THE laryngologist sees upper respiratory infection from a different angle than does the internist and pediatrician. Usually he is consulted for the later complications such as sinusitis, otitis media or laryngitis.

However, he does see patients at the onset of an upper respiratory infection when most of the infection is in the nasopharynx and treatment of this area is of primary importance if complications are to be averted. Formerly the nasopharynx was painted with iodine and glycerin and the middle turbinate region of the nose shrunken and packed with argyrol or a period of 10-15 minutes. Now tyrothricin 1:5000 is used instead of argyrol, or sulfadiazine in 2½% solution may be used. It is now well established that either tyrothricin or sulfadiazine used as a spray will prevent the complications of upper respiratory infection if used in the invasive stage.

Whether the original infection is virus or bacterial, the complications are almost always bacterial, representing secondary invasion by streptococci and staphylococci. Acute sinusitis is the most common of these complications seen in the laryngologist's office. Treatment with vasoconstrictors to promote free drainage is followed by some antiseptic such as the sulfa drugs, penicillin, tyrothricin and even argyrol. The objection to vasoconstrictors is that they diminish the blood supply of the nose in the face of infection but this is over-ruled by the necessity of establishing drainage. The antiseptic drops commonly used also have their disadvantages. Sulfathiazol is extremely irritating to the nose, not only causing paralysis of the ciliary action but also destruction of the mucous membrane. The same can be said for penicillin in strength above 250 units per c c. Furthermore, it is necessary for these agents to remain in contact with the bacteria for a period of 2½ hours, which is difficult to accomplish. 1% Ephedrine and saline is the most common form of nose drops in general use but ordinary oil nose drops with a little menthol and camphor is better tolerated by most patients.

During the Christmas holidays just past it was estimated that there were 32,000,000 cases of upper respiratory infections in the United States and Providence had its share of these. There appeared to be four distinct epidemics present at the same time. First there was the so-called influenza which was of more interest to the internist than to the laryngologist, although a few cases of sinusitis came from this epidemic.

Secondly, there was the epidemic of gastro-enteritis, intestinal grippe, which also was of little interest to the laryngologist.

Third, we had an epidemic of sore throat caused by the hemolytic streptococcus. This was characterized by very severe sore throat with a tendency

to acute otitis media. The throat showed little membrane but the anterior portion of the tongue gave a typical strawberry appearance. Without exception this disease yielded to sulfadiazine.

I saw only one patient come to operation for mastoiditis. This case had been treated with sulfadiazine which had effectively masked the symptoms. The relapse was treated in the hospital with penicillin which apparently cured the patient, giving a dry ear. However, about four weeks after the onset the patient suddenly developed typical signs of surgical mastoiditis as the infection broke through the cortex of the mastoid. At operation the mastoid was completely broken down and filled with pus which showed hemolytic streptococcus on pure culture.

The fourth infection, which is epidemic at this time, furnished most of the work for the otolaryngologist. Undoubtedly a virus infection, it began with an intense rhinitis which lasted for three days and then almost immediately involved the sinuses. A catarrhal otitis was a frequent complication but was not as severe as the suppurative otitis started by the streptococcus epidemic. The sinusitis was very refractory to treatment and lasted from three to five weeks. There is evidence that penicillin and sulfadiazine sprays headed off the sinus complication in many of these infections if used during the first three days. Once the sinusitis was established, no such results were obtainable. Cultures taken from the middle turbinate region on these cases showed staphylococcus in 6 cases, streptococcus viridans in 6, Micrococcus catarrhalis in 12 and four were sterile. The cultures were planted on blood agar. These results were inconclusive and indicated that the organism was a virus or was of such a nature that it did not grow on ordinary culture media. It is just possible that this infection was the same one that caused the gastro-enteritis; at any rate, the gastro-enteritis and sinusitis were present in many patients at about the same time.

The sinus infections following this infection did not yield to chemotherapy by mouth. If the infection was in the maxillary sinuses, irrigation with penicillin cleared the condition, but unfortunately we were usually dealing with an ethmoiditis. Procedures designed to introduce solutions into the ethmoids are complicated and not without the danger of spreading infection to the ears.

The sulfa drugs and penicillin have revolutionized the treatment of otitis media, greatly lessening its severity and reducing mastoidectomy to 90%. No comparable results are evident in the treatment of sinusitis but with more careful bacteriological study and better selection of the sulfonamides or antibiotics to be employed, comparably favorable results in the treatment of sinusitis can be expected.

ACUTE RESPIRATORY INFECTIONS FROM THE INTERNIST'S VIEWPOINT

MORGAN CUTTS, M.D.
Assistant Physician, Visiting Staff, Department of Medicine, Rhode Island Hospital

THE whole problem of dealing with acute respiratory infections today resolves itself into distinguishing between bacterial and virus etiology. Both affect the bronchi and the lungs, and can produce serious illnesses which are roughly comparable. But upon knowing which type of agent is involved rests much of the diagnosis treatment and prognosis in any particular case.

Acute bronchitis is a good example of this. Influenza and virus pneumonia both in themselves cause inflammation of the bronchi, as do also Staph, Strep, and Pneumococci. The dry hacking cough sometimes seen in influenza may change to a purulent bronchitis after the first few days with rising WBC, Hemolytic Strep in the sputum, and a good response to diazine or penicillin—whereas at first both would have been without effect. Only making a diagnosis of bronchitis does little more than say the patient has a cough, and unless one goes further to the cause of his bronchitis, does little to help in his treatment. The WBC is probably the most useful single aid in making this decision. For symptomatic treatment, inhalations, expectorants if the cough is dry, or codein if it is too exhausting are of course helpful. If diazine is decided on it should be given in full doses with care for adequate fluid intake. 100,000 u. of penicillin/day i.m. is sufficient dosage. I believe that if specific treatment is tried without definite indication it is often disappointing, and should be discontinued after 48 hours if no improvements results.

If a diagnosis is made of a virus infection it is often difficult to distinguish between the various ones, of which there are many varieties both known

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and unknown. It is worth attempting however in the case of two of them, influenza and virus pneumonia, because of the very different course. Typically influenza has a sudden onset, after a brief incubation period, of chill, rapidly rising fever, prostration, and general aching without localizing signs. There is a leukopenia and may be a non-productive cough. This is in contrast to the longer incubation period, and slowly increasing symptoms and fever of virus pneumonia. Also uncomplicated influenza lasts only 3-4 days, so with continuing illness it must be assumed that (1) there is infection due to secondary invaders or (2) that the whole disease was due to bacteria or to some virus other than influenza A or B.

The treatment of uncomplicated influenza is purely symptomatic. Some people ask—"why not give penicillin to all patients with flu or grippe prophylactically to prevent secondary bacterial invasion and thereby shorten the illness?" My belief is (1) most of the patients don't need it and do just as well without it, and (2) it makes for careless treatment and may confuse the diagnosis. It should certainly not be given in inadequate dosage.

An influenza vaccine is now on the market, made of equal parts of A and B. Trials have demonstrated that this vaccine affords definite but probably only brief protection—on the average the controls contracted the disease 3.2 times as often as the vaccinated. This effect persists for a few weeks or months—Reiman recommends its use only at the beginning of an epidemic whose etiology is established.

The recognition of "virus" pneumonia is less than 10 years old, yet in 1943 it was diagnosed 4 to 8 times more often in many Army hospitals than bacterial pneumonia. Once the main problem was to make a diagnosis of the type of pneumococcus, now the essential decision is whether a pneumonia is bacterial or virus. The differential points are—(1) Onset. This is gradual in virus, with no chill, pain in the chest and bloody sputum, the cough is non-productive and the fever lower at the onset. (2) P.E.—this may show little or nothing in virus pneumonia, and usually not the frank consolidation of a lobar pneumonia. (3) WBC, normal or slowly rising in the later stages or virus pneumonia (4) X-ray changes. These are more patchy and inconstant in virus pneumonia, described as fan-shaped or wedge-shaped, often extending out from the hilus into the lower lobes, and shifting from one lobe to another.

Just as chemotherapy has completely replaced serum in the treatment of bacterial pneumonia, so penicillin is in the process of replacing diazine in this disease. It is less toxic and it has a greater and wider effectiveness. The only advantage of diazine now is that it can still be given more easily at home, but even this advantage will probably vanish as oral preparations of penicillin become available that are cheaper and more regularly absorbed. Parenteral dosage of penicillin for lobar pneumonia varies between 80,000u/day and 300,000u/day—about 150,000 is probably a safe average. I believe it should be given q 3 h at first, and continued for 2 or 3 days after normal temperature in slightly lower dosage.

The use of penicillin by mouth requires 5 to 10 times the i.m. dose, and absorption is more irregular and uncertain. However, it has been used successfully in treating pneumonia, in doses of 750,000 u per day, and experimental trials are continuing.

Penicillin by inhalation is under trial now in many places. It has been used for bronchiectasis and in lung infections preoperatively, and pneumonia has been successfully treated by this means alone. 25,000 u of penicillin are dissolved in 1 or 2 cc of saline nebulized by an intermittent stream of O_2, and inhaled over a 15 minute period. This is done several times a day. It may be that this form of treatment will ultimately prove very useful in bronchitis of bacterial origin.

In practice the most vexing question is whether or not to start penicillin or diazine in an acute respiratory infection other than bacterial pneumonia. With uncomplicated influenza I believe the answer is definitely no. With virus pneumonia it is usually no, though in the latter part of the disease it is sometimes worth trying, depending on the general course, type of sputum, and WBC. But there are many other clinical pictures, not so clear-cut, starting like "grippe" or "flu", but continuing with varying fever, cough and generalized symptoms for weeks. It is in these that one is so often urged to try either the sulfonamides or penicillin. Personally I do so only rarely, when there is some increase in the WBC after the first week of illness. It is usually without effect, and if so should not be continued more than a few days. The distressing fact is that we have no specific treatment for most acute respiratory diseases—we should at least not burden the patient with useless therapy.

DISCUSSION

Dr. Burgess: It does not seem to me that we have developed any great antagonisms here, but perhaps we can get a few points that we do not agree upon. Before doing so I would like to comment a little and add one or two things that I think are quite important. First, regarding the causes of upper respiratory infections, we were taught to believe that drafts and chilling are factors in bring-

ing them on. I would like to call to your attention the report of William H. Harris, medical officer on a destroyer, who noted that in his ship's company all respiratory infections tended to disappear from two to six weeks when at sea and that no matter how much the exposure to cold or drafts and regardless of fatigue and loss of sleep, they did not start again until contact was made with other vessels or the shore. Another matter of interest—there has been reported a series of cases in which 20 per cent of the pneumococcal infections were indistinguishable from so-called primary atypical pneumonia including white blood count and x-ray appearance, and these cases responded very well to penicillin. I believe in an older person, or in one very ill, it is wrong to withhold the relatively harmless penicillin. I do not think we have mentioned how to treat the common acute follicular tonsillitis although Dr. Sargent did touch upon it.

Question: Dr. Sargent, is there any harm in letting mastoiditis quiet down by itself? You said you did not open an ear drum unless it was bulging.

Answer: No. if you feel certain that it will quiet down. In the absence of fever or pain I think that is right, but often I have seen one that developed in two or three days after being treated. Whether they would have if they had been opened I do not know. I think it is safer to open it.

Dr. Calder: I have seen that happen before we had sulfa. The ear would quiet down. I think a mastoiditis can go along more or less independently.

Dr. Burgess: Any further questions Dr. Calder?

Dr. Calder: I want to ask Dr. Cutts if a low white blood count may occur in a bacterial pneumonia.

Dr. M. Cutts: Yes, that is true, but the exception would prove the rule.

Question: You would agree that in a case of doubt you would not delay.

Dr. M. Cutts: Yes. White blood count is only a guide.

Dr. Sargent: I commented on tonsillitis. If the infection is hemolytic streptococcus you should give sulfadiazine. I did not speak of peritonsillar abscess but that is much better handled now since we have the new drug. It used to be a bad thing to have to let it ripen. Now, sulfadiazine seems to bring it to a head more quickly.

Dr. Cutts: I was interested in an article about primary atypical pneumonia and the use of one of the sulfonamides in early stage. It was given to a group and at that time reported that it was very effective in cutting down severe respiratory disease. This fall a followup article came along and described an epidemic of scarlet fever and hemolytic streptococcus infections due to two organisms which were sulfonamide resistant which had developed in that situation after a few months of treatment with sulfonamides.

Dr. Burgess: I recall that only two years ago Dr. Utter and Dr. Gregory had a few questions on this matter. Have you anything to say Dr. Gregory?

Dr. Gregory: No. I think the subject has been thoroughly discussed. I still go along with the idea of giving adequate doses of sulfadiazine or penicillin. Once I make up my mind to give it I give adequate doses. I think small doses either does the patient little good or no good at all. In other words, the patient would probably get well anyway. I cannot see how one, two or three milligrams in the blood will cure an hemolytic streptococcus infection. You have to have adequate dosage. Once I make up my mind to give sulfa I give adequate dosage. I may say in my short time in practice I have found quite a few patients with hemolytic streptococcus infections of the nasopharynx. I find they have had a course of sulfa three or four times and the patients are very pale and weak. I check the blood and urine and some had marked anemia and white blood count was low which makes the use of sulfa out of the question. I fall back on an experiment which Dr. Morgan Cutts did in the Charles V. Chapin Hospital laboratory a few years ago in which the use of small doses of sulfonamides enhanced the tolerance of H. S. so that when later on you gave adequate doses it did not stop the growth. In pneumonia I find that smaller doses do no good at all. As for peritonsillar abscess I think, very rarely have we opened a peritonsillar abscess. They come and for the first one or two days are very painful. When it localizes there is no pain at all.

Dr. Burgess: I think we are very much pleased with what Dr. Gregory says.

Dr. Calder: I agree in giving sulfa that at the beginning you should give enough. On the other hand you should reduce the dose as quickly as possible. Most of the toxic results in children are when they receive it for more than five days. The dose should be reduced as rapidly as consistent with improvement.

Dr. Kramer: I would like to ask Dr. Cutts what the difference is between the bacteria in bronchopneumonia and the later stages of virus penumonia. I could never find out because you do find various types of organisms. I have been impressed by the lack of value of penicillin in the usual brochopneumonia especially in the young and those who do not have a very high temperature.

Dr. Cutts: I do not see very much bronchopneumonia any more. I think they are usually lobar pneumonias which are bacterial or primary atypical

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pneumonias. I wonder if the finding of very little response to specific treatment in bronchopneumonia means that they are really primary atypical pneumonias. You get a high percentage of pneumococci in throats. You also may find them at any time in any sputum coughed up in an atypical pneumonia. I do not think their presence means the disease is due to the pneumococci in question. Those who do not respond to penicillin are due to virus.

Dr. Burgess: My own experience has been quite the opposite. I have seen a great many bronchopneumonias particularly in older people who have responded very well and quickly to penicillin.

Dr. Utter: Tonsillitis should be treated with sulfa drug. A tonsillitis may run its course in spite of the drug. It starts in the superficial tissues of the tonsils and works into the crypt of the tonsil. At the end of five days the crypt begins to discharge. Many a time a doctor looks at a throat one day and says the child has no infection. Three or four days later he would find the tonsils swollen. If we give the sulfa drug we will prevent complications. What has become of the cervical adenitis that we used to see before the days of sulfa? You see it no longer if you give sulfa. In using sulfa we prevent the spread of infection from the Eustachian tube into the middle ear. We should give sulfa in tonsillitis always. Also in virus infections.

What is the relationship between virus infection and bacterial infection. Many have pneumococci. Virus stimulates the growth of hemolytic streptococcus in the throat. That is why the course of virus infections gives us complications. Practically always in virus infections we have other bacteria. I believe we should give sulfa in the course of virus infections. I have gone through five years of measles without complicatory infection. One other thing, the question of fear of sulfa drug and the organism becoming fast to the sulfa drug. The sulfa drugs are eliminated within thirty-six hours. How is that drug, which is entirely eliminated, going to become fast to an organism which we may meet next week or next month. We do not meet the same organism each day. I have given sulfa to children dozens of times, and I have never seen these organisms become fast.

THE WOOD LIGHT

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THE HEALTH ACT

On April 3 the proposed health act drafted by a special public health survey laws commission of fifteen members was printed and distributed by the General Assembly. The printing of the act provided the first opportunity for the Rhode Island Medical Society, the largest professional group affected by the proposed legislation, to know of the proposals of the commission. On April 4 the joint committee on health of the General Assembly called a hearing on the bill. The Society reported that it could not comment until its Committee on Public Laws had viewed the legislation, and it promised to submit recommendations in writing within the following week. On April 10 the Society, through the Committee on Public Laws, made known in writing to the Assembly committee its recommendations for amending the bill. That committee accepted but three minor amendments, and then reported the bill out with approval. The House passed the act. The Senate objected that it had been introduced too late in the session, that sufficient time was not allowed for careful study of it, and therefore it should be held until the next session of the Assembly. The latter action prevailed. Subsequently the chairman of the Joint Committee on Public Health secured passage of resolution to continue the special survey laws commission until next February. Such, in brief, is the legislative history of the health act.

The action of the Society in no manner criticized the work of the commission that undoubtedly gave generously of its time to improve the present health laws. For that matter when the resolution that created the commission was before the Assembly in 1943 the Society pointed out to that body that the amount of work planned could not be completed in the allotted time, and it recommended that the proposal be amended to include legal representatives to assist in the task.

Although the Commission had been in service since 1943, it had never requested the Rhode Island Medical Society to come before it at any time to make known any of its views, or to assist in forming any decisions that would mainly affect the medical profession of this state. Therefore, the Society had no alternative other than a presentation of amendments when the legislation was finally before the Assembly and available for public reading.

Three amendments of the approximately twenty-one amendments submitted by the Society were approved by the Public Health Committee of the Assembly. Strange to relate, the major amendment accepted, that relative to the right to require full citizenship as a prerequisite for licensure, was accepted only in part, thereby making the amendment as accepted inconsistent with a parallel provision further in the act..

continued on next page

The major objections of the Society, as clearly set forth in published statements pointing to faults existing in the present or proposed laws, included the following: failure to clarify the term "physician" which in some instances applies only to a doctor of medicine and in others to an osteopathic or a chiropractic physician also; failure to improve the cancer control program as long advocated by the Society, whereby a cancer commission would initiate a long-range program in cooperation with the state health department; failure to amend properly the clarification relative to citizenship requirements; failure to make provision for the exemption of state licensure for physicians in the newly created Veterans Administration Corps, as is provided for the Army, the Navy, and the USPHS; failure to clarify just what constitutes the practice of osteopathy in this state; failure to clarify the very ambiguous term "major surgery" used in the law without definition of what it constitutes; and failure to present evidence to justify the extension of privileges to chiropractic physicians beyond the scope of their recognized training.

The Society by no means merely presented objections to these faults. It honestly and conscientiously attempted to correct them by submitting amendments that did not deprive anyone now licensed under the healing art of privileges within the scope of his recognized training and licensure.

The health act now goes back to the study commission. It is to be hoped that public hearings for the purpose of discussing the views of the Rhode Island Medical Society, as well as those of other interested groups, may be held in ample time to permit the improvement of the act for presentation early in the January session of 1947.

DR. OLIN WEST

On April 1 Dr. Olin West retired as secretary-general manager of the American Medical Association. For well on towards a quarter century his name has been familiar to all its members. They knew that over this long period he had done a good part in running this great and beneficent organization. A smaller, but still large number of physicians, members of the House of Delegates, state secretaries and editors of state journals, had in their frequent trips to Chicago made intimate contact with him and become well acquainted.

This group particularly are going to miss his presence at their meetings. He was the guiding spirit. He knew all the answers. He was always right there seeing that things were moving in the proper direction and smoothly. There was no doubt that he was a capable, efficient secretary-manager. But what lingers longest and most fondly is his personality. His deep, well-modulated voice has just enough southern accent to let you know where he came from. This, joined with his long gaunt form, slender face and graying hair, suggests Henry Clay or possibly Davy Crockett, but not John C. Calhoun or Andrew Jackson. There is nothing of the fire-eating Southerner about him. His kindly ways and friendly manners are as far from this as possible. If one hobnobs with him in a small group and hears his charmingly told stories of life below the Mason-Dixon line, one is reminded then of Joel Chandler Harris of Uncle Remus fame.

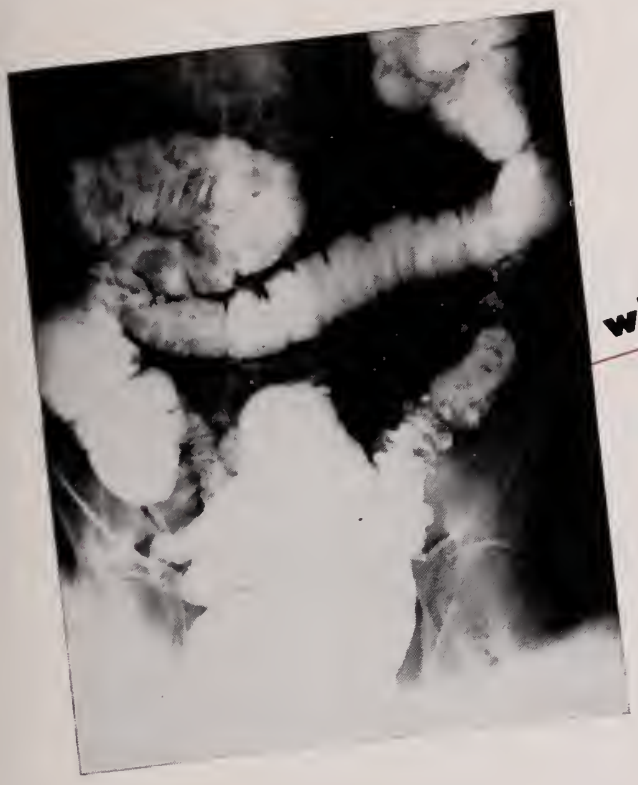
His career, almost entirely devoted to organized medicine, is sketched in a recent number of J. A. M. A. and a well deserved tribute is paid there to the value of his work. May he still continue to lend his counsel and advice, but avoid responsibility and enjoy a dolce far nienti, away we trust, at times, from the rigorous lake breezes of Chicago and in the soft Southern clime of his boyhood.

A WOMAN'S AUXILIARY

The proposal that the Society have a woman's auxiliary is certainly a commendable one. The value of such an organization has been well demonstrated in forty-two states, and it is surprising to know that we in Rhode Island have been one of the last to recognize the fact that our wives form one of organized medicine's greatest assets. Not alone because they have suffered with us all these years, watching us disappear day and night on sick calls or to medical meetings and conferences, but more because they, of all groups, best understand and appreciate the scope of the physician's work, do our wives deserve this recognition as an affiliate of our historic medical society.

When the war forced the elimination of our annual Society dinner the social hour substituted, to which wives of members were invited, proved one of the highlights of the annual meeting. There is little doubt, then, that as a social organization the Auxiliary would be successful; as a formidable group to carry to every corner of our State the story of organized medicine, its ideals, its purposes, and its plans for the benefit of all the people, its possibilities are limitless.

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HERMAN C. PITTS, M.D.

of Providence, R. I.

President of the RHODE ISLAND MEDICAL SOCIETY

1946-47

To the Officers and Fellows of the Rhode Island Medical Society

There is nothing static in all this universe of ours. Even the "eternal hills" are not eternal, for every year their heighth and bulk are reduced by the erosion of wind and water.

Alas, Medical Societies are not exempt from this general law. They must go forward or else slip back to a plane of lesser usefulness and lesser influence!

As your leader for the coming year, I can see several problems ahead that will need the hearty efforts of every one for their satisfactory solution.

First of all the acceptance by the Members of the Society of the proposed Voluntary Surgical Benefits Plan. Your House of Delegates has pledged itself to the establishment of such a plan. The one proposed may not be ideal—no plan can suit every one. But let us all get behind the one finally adopted, give it a thorough trial and then when weak spots are found, strengthen them. I believe that whatever we can do to develop any type of voluntary health insurance erects a barrier against the adoption of a national compulsory health insurance law that will certainly put us in the same unfortunate position the English physicians find themselves.

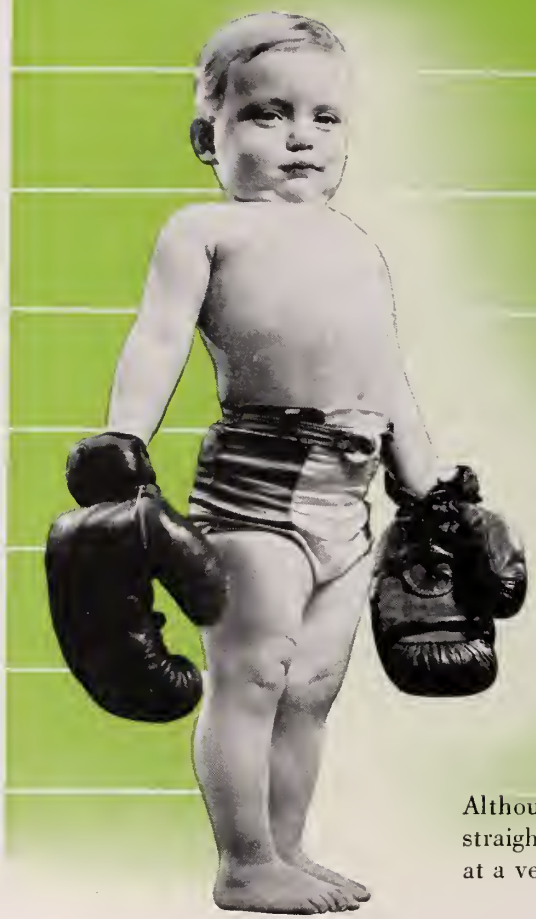
Then we have the returned veteran. We owe him a great debt for the sacrifices he has made in defense of our country. Whatever we can give him of our time and skill is a very small payment against that debt. That we should be helpful and generous at all times to our professional associates returned from the armed forces goes without saying.

I should like to emphasize what my far-sighted predecessor has already said, Viz., that we as Members of the State Medical Society should take a greater interest in the making and enforcing of laws dealing with the health problems of the whole state. The pollution of our bay waters for instance is a disgrace. It affects not only the pleasure of our people but also their health. We can exert some influence surely by talking and writing in obtaining better conditions.

Lastly I should like to emphasize again that public relations begin, and I might say end, with the conduct of each member of our profession. The public judges standing and worth by the skill, patience, tact and honesty each one of us exercises toward each patient.

I ask for the help and co-operation of you all. With it, we can advance to a position of greater influence and of greater usefulness to the community.

Herman C. Pitts, M.D., *President*



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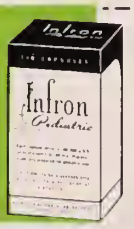
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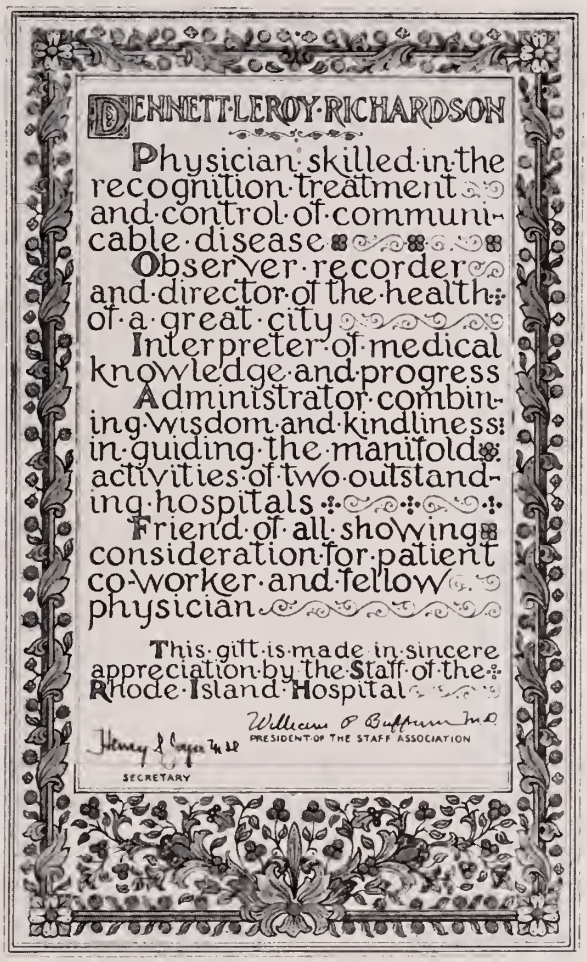
THE STATE HOSPITAL FOR MENTAL DISEASES

HOWARD, RHODE ISLAND

SEVEN miles southwest of Providence on Reservoir Avenue is situated the Rhode Island Hospital for Mental Diseases with its modern equipment and competent staff of Doctors, Nurses, and associate personnel. This institution represents the untiring and ceaseless efforts of the progressive forces in the State in seeking humane care for their less fortunate comrades. The history and development of this hospital to its present status should therefore be of interest to us.

During the sessions of the Rhode Island Assembly from 1867 to 1869, various resolutions were adopted leading to the purchase of the Wm. A. Howard Farm in Cranston and the creation of the State Board of Charities and Corrections. This land was to be used for the construction of the House of Correction and the State Asylum for the Insane, and for what other purposes the General Assembly might direct. The first meeting of the Board was held July 30, 1869. The Chairman was authorized to procure specifications and estimates for the construction of one-story buildings to house the incurable pauper insane. These buildings were to be patterned after those at the lunatic asylum, Blackwells Island, New York. Construction was finally completed and the first patients admitted on November 7, 1870. Until March 1, 1885 the state law limited admissions to state and town charges who were incurably insane. On the above date, the General Assembly passed laws which made it possible for the commitment of recent cases of insanity to the asylum without prior treatment at a hospital which cared for acute cases. The State, in consequence, accepted the responsibility for all types of mental disease. The administrative control of the hospital can be divided into two periods, the period of the State Farm and Deputy Superintendencies which lasted from November 7, 1870 to May 21, 1897 and the period of Medical Superintendencies commencing May 21, 1897 and extending to present day. During the first period, the Superintendent of the State Farm was charged with the administration of four (4) departments, the House of Correction, the State Work House, the State Almshouse and the Asylum for the

continued on next page


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Facsimile of the citation to Dr. Dennett L. Richardson by the staff of Rhode Island Hospital on the occasion of his retirement as Superintendent.



STATE HOSPITAL FOR MENTAL DISEASES

continued from previous page

Chronic Insane. The Superintendent of the State Farm was responsible to the State Board of Charities and Correction for his administration and each of the four departmental heads or Deputy Superintendents were responsible to him.

An act was passed by the General Assembly in 1897 separating the hospital from the State Farm and changing its name to the State Hospital for the Insane. The Board of Charities and Correction was authorized to appoint a Superintendent for the hospital who should be a physician. The first Medical Superintendent took office May 21, 1897. From 1897 to 1912 further expansion of the physical plant took place which more adequately met the needs of the patients. There was also constant agitation for an enlarged medical staff, for better medical and surgical facilities, and the creation of a Nursing Staff and School.

On May 28, 1912, a Reception Hospital was completed and occupied. Soon after its occupancy, there was established a modern department of Pathology and Laboratories, a Nursing Staff and School, Department of Occupational Therapy, and a Surgical and X-Ray unit. In 1915 the first class of Nurses was graduated. In 1916 a Social Service Worker was added to the Staff. This service has since expanded into a department with five full time workers and sponsors a training course for students. By 1932 the Mental Hygiene Program sponsored by the hospital was expanded and Community Mental Hygiene Clinics were established in outlying districts in the State. These were under the hospital's jurisdiction and staffed by personnel from the hospital. A new building program was initiated in 1934 and completed in 1938. The hospital was then divided into the following services and remains the same to this day. These services are: The Individual Treatment Service, the Medical and Surgical Service, Senile Service, Male and Female Continuous Treatment Service, Tuberculosis Sanitarium, Criminal Insane, and Department of Pathology and Laboratories. There has also existed in the hospital for many years, a consultant staff made up of outstanding specialists in the State in the various specialties. The people in the State of Rhode Island owe these men a debt of sincere gratitude for their untiring efforts and interest on behalf of the patients for which they receive no compensation. Until the onset of World War II, there was an active educational program for doctors, nurses, and the personnel of the various departments in their respective fields. During the War certain departments found it necessary to operate with skeleton crews because of help shortages resulting in some regression of service. Most gains have been maintained,

continued on page 390

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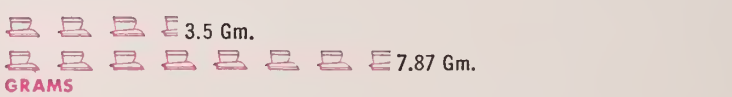
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HOSPITAL LEGISLATION ENACTED BY GENERAL ASSEMBLY

SENATE ACT 245

(Passed in concurrence by the R. I. General Assembly on April 17, 1946)

TO INCORPORATE
KENT COUNTY MEMORIAL HOSPITAL

SECTION 1. Whitman Merrill, M.D., President of Kent County Medical Society, Peter Erinakes, M.D., Vice-President of Kent County Medical Society, Jeannette E. Vidal, M.D., Secretary of Kent County Medical Society, and John A. Mack, M.D., Treasurer of Kent County Medical Society, and their associates, who may be admitted to membership of the corporation hereinafter created according to the by-laws thereof, are hereby made a corporation by the name of Kent County Memorial Hospital for the purpose of organizing, erecting, acquiring, equipping, supporting, operating and maintaining a non-profit hospital for the sick, disabled and injured in Kent County, in the State of Rhode Island; and in connection therewith and for the purpose of carrying into full effect the charitable and humane intentions of the corporation, to acquire land by purchase, lease, gift or devise, and to erect thereon or otherwise acquire suitable buildings and equipment, with all powers and privileges and subject to all other duties and liabilities set forth in chapter 259 of the general laws of 1938, and in any acts in amendment thereof or in addition thereto.

SEC. 2. The said corporation may take and receive, hold, purchase and possess real and personal estate to be used and employed for the erection, support, operation and maintenance of a hospital in Kent County in the State of Rhode Island, and for carrying into full effect the charitable and humane intentions of the corporation to any amount necessary or proper, but not to exceed $5,000,000.00: and may sell and dispose of the same; and the property and estate of said corporation, both real and personal, shall not at any time be liable to be assessed in the apportionment of any state, city or town tax.

SEC. 3. In addition to all other purposes said corporation is hereby authorized, and empowered to carry on the work of educating and training nurses, and, for that purpose, to institute and maintain a training school for nurses and to grant certificates for work performed at such school and diplomas to graduates thereof.

SEC. 4. This act shall take effect from and after its passage.

Final Action

HOUSE RESOLUTION — 1028

(Passed by the House of Representatives, R. I. General Assembly, 1946)

REQUESTING HIS EXCELLENCY, GOVERNOR JOHN O. PASTORE, TO APPOINT A SPECIAL COMMITTEE TO MAKE A SURVEY OF THE NEED FOR A SMALL STATE-OPERATED HOSPITAL UPON THE ISLAND OF BLOCK ISLAND IN THE TOWN OF NEW SHOREHAM, RHODE ISLAND.

RESOLVED, That His Excellency, Governor John O. Pastore, be and he hereby is requested to appoint a special committee, consisting of five members of the medical profession, to make a survey of the need for a small state-operated hospital upon the Island of Block Island in the town of New Shoreham, Rhode Island. The members of said special committee shall serve without compensation and shall report their findings forthwith to the governor with recommendations, if any, for legislation to activate such recommendations, said legislation to be presented to the general assembly at its 1947 January session.

SENATE ACT 23

(Passed in concurrence by the R. I. General Assembly, April 17, 1946)

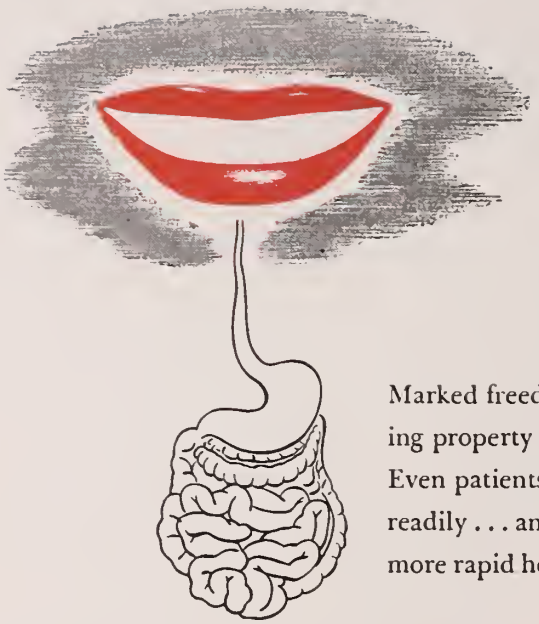
JOINT RESOLUTION

CREATING A SPECIAL COMMITTEE TO STUDY THE ADVISABILITY OF CHANGING THE NAME OF THE STATE SANATORIUM AT WALLUM LAKE, IN THE TOWN OF BURRILLVILLE, RHODE ISLAND TO "THE HARRY LEE BARNES SANATORIUM."

RESOLVED, That a special committee be and the same hereby is created, consisting of five members, two of whom shall be appointed by the presiding officer of the senate and three of whom shall be appointed by the speaker of the house of representatives, for the purpose of studying the advisability of changing the name of the state sanatorium at Wallum Lake, in the town of Burrillville, to "THE HARRY LEE BARNES SANATORIUM," out of respect to the memory of a pioneer in this state in the field of tuberculosis who gave so many years of his life to the upbuilding of the state's institution for consumptives.

The members of said committee shall serve without compensation and shall report to the general assembly on or before the fifteenth day of February, 1946.

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*Reznikoff, P., and Goebel, W. F.; J. Clin. Investigation 16:547, 1937

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DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

The regular bi-monthly meeting of the Newport County Medical Society was held on March 26, 1946, at the Newport Hospital.

The meeting was opened at 8:55 P. M. with Dr. Alfred M. Tartaglino presiding.

The minutes of the January meeting were read and approved.

A letter from the Newport-Jamestown Bridge Commission requesting support of legislation pending in the Rhode Island Legislature was circulated.

A communication was received from Mr. Harry Feigelman inviting members of the society to be present at a meeting of the Newport Bar Association, at which Dr. McCarthy, the medical legal expert, was to be the principal speaker.

Dr. Frank W. Dimmitt was introduced and discussed the question of prepaid surgical service in Rhode Island under the sponsorship of the Rhode Island Medical Society. He stated that if such a plan were to be instituted, it seemed desirable to have it sold by the Blue Cross organization because of their low operating cost and their efficient going organization. He stated that, thus far, an enabling act had been passed by the legislature permitting this type of enterprise and that the Blue Cross had enlarged its board of directors to include a larger number of physicians. He stated that one of the things now being discussed was whether the plan would be on a service or on an indemnity basis, but stated that the Blue Cross was not interested in an indemnity plan. The New Jersey, New York City, Massachusetts and Michigan plans had been consulted in setting up a fee schedule. The plan in Rhode Island was being figured to include obstetrics and surgery in the home, office or hospital. One problem was a question of a fee differential for board members and members of the society in general. The question of the assistant's fee and the anesthetist's fee were in the process of being ironed out. As tentatively set up, the plan was to be restricted to single individuals, whose income was $2,000 a year, or under, and to married persons with an income of $2,500 a year or less. It was planned to indemnify other subscribers whose incomes are above the forementioned. In conclusion, he stated that while many kinks remain to be ironed out the individual members of the society would be asked to vote upon the plan before it would become effective.

Dr. Albert Jackvony then discussed a number of the questions which had been submitted to him by various interested members of the society in Providence, and he attempted to answer the various problems which they represented.

Dr. Samuel Adelson and Dr. James Callahan, delegates to the state society, who had had a part in the shaping of the society's plan, then gave their opinions of the plan in its present form.

Following a discussion by the members in general, the meeting adjourned at 10:35 P. M.

A collation followed.

Respectfully submitted,
H. W. Brownell, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held Monday evening, April 22, 1946, at the Pawtucket Golf Club. The transfer of Dr. Reginald H. Boucher from the Providence Medical Association to the Pawtucket Medical Association was received and approved.

Dr. James P. Healy, former Army Medical colonel of the 87th Infantry Division, gave an enlightening and interesting discourse on "Medical Service of a Division." Following Dr. Healy's lecture a collation was served.

Respectfully submitted,
Kieran W. Hennessey, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, April 1, 1946.

There being no objection, the reading of the minutes of the previous meeting was omitted.

The Secretary reported the receipt of a communication from the Public Health Nurses Association calling attention to a series of meetings to be held at the Providence Lying-In Hospital to which members of the profession are invited.

continued on next page

The Secretary also announced that the Rhode Island Tuberculosis Association extended an invitation to all physicians to hear Dr. Richard H. Overholt, Chief of Thoracic Surgery at the State Sanitarium address the Annual Meeting of the Tuberculosis Association to be held at the Medical Library on Wednesday, April 10.

The Secretary reported for the Executive Committee as follows:

> At a recent meeting the Executive Committee of the Association approved the transfer of membership of Dr. Warren Ruhmann to the Kent County Medical Society, and of Dr. Reginald H. Boucher to the Pawtucket Medical Association.
>
> The Committee also recommended to the Association the election to associate membership of the following: Drs. Reginald H. Boucher, Francis D. Lamb of the Kent County Society, and Dr. Warren Ruhmann.

On a move from the floor the report was accepted and associate membership granted to the members named by the Executive Committee.

The President called on Dr. Edward S. Cameron, Chairman of the Air Pollution Committee, who presented the following report for his committee which consists of himself, Dr. Alex M. Burgess, Dr. Anthony Corvese, and Dr. B. Earl Clarke:

> "An act authorizing cities and towns in Rhode Island to control air pollution has been submitted to the General Assembly through the efforts of the Civic Committee on Air Pollution appointed by Mayor Dennis J. Roberts of Providence. The Committee on Air Pollution of the Providence Medical Association feels that the passage of this act would be very desirable and would pave the way for a modern up-to-date ordinance for Providence and for the other cities and towns in this State.
>
> "The Committee also reports that Mr. Philip Mancini, Public Service Engineer of the City of Providence, has an excellent proposal for an additional approach to the problem. He plans to furnish every fuel dealer with a printed card listing fuel burning instructions which the dealer will in turn deliver to each of his customers. Mr. Mancini plans to give public notice of this program in the daily press."

After Dr. Cameron's report Dr. Robert H. Whitmarsh placed before the membership the following recommendations:

> "1. That the Providence Medical Association give its endorsement to House Bill 870, an act authorizing cities and towns to control air pollution, which has been submitted to the Rhode Island General Assembly through the efforts of the Providence Civic Committee for Air Pollution Control,
>
> "2. That the Narragansett Electric Company be commended for its plans for smoke and dust control at its plant, and that it be commended for its leadership and foresightedness which should stimulate other industrial plants, large and small, to adopt similar measures,
>
> "3. That the Providence Public Service Engineer, Mr. Philip Mancini, be encouraged in his public educational campaign to inform fuel consumers, including especially the residential and apartment house groups, regarding proper instructions for fuel burning to lessen air pollution."

The motion was made, seconded and unanimously supported that these recommendations be adopted by the Association.

The President reported that an Obituary Committee of which Dr. Edward T. Streker is Chairman has been appointed to prepare the tribute of the Association to the late Dr. Howard Keefe.

The President announced that Dr. Robert R. Linton of Boston will address the Association at the meeting on May 6 on the subject, "Thrombo-Embolic Disease — Prevention and Treatment with Special Reference to Femoral Vein Interruption."

The President called upon Dr. Herman C. Pitts who briefly addressed the members and called attention to the Ball to be held at Rhodes for the benefit of the Field Army for the control of cancer. He urged that as many members as find it possible to do so purchase tickets to support this excellent movement.

The President called upon Dr. Guy W. Wells to preside over the panel discussion of experiences in World War II as related by the following physicians: Dr. Kenneth Burton, Dr. Alphonse R. Cardi, Dr. Samuel D. Clark, Dr. Nicholas A. Pournaras, and Dr. Wells.

Dr. Kenneth G. Burton was the first speaker and described his experiences as a member of a specialized surgical team, caring primarily for orthopedic casualties. During his period of service his team worked with field hospitals, general hospitals and evacuation hospitals in England, France and Germany. He described in interesting detail, the routine of work, living and moving from place to place. Some interesting examples of the confusion incident to mobile warfare were related. In one instance, his field hospital was nearer the front lines than the collecting station, and patients were evacuated from it, forward towards the front lines. There were several episodes of steady, unremitting work for as long as thirty-six hours at one stretch.

continued on page 379

DIAGNOSTIC DILEMMA



A diagnostic dilemma presents itself when the physical examination and laboratory findings are normal in the man of fifty complaining of easy fatigability, nervousness, insomnia, vasomotor disturbances and diminished recuperative power. While such symptoms may be due to psychogenic causes, failing testicular function should be kept in mind. A therapeutic test with ORETON (testosterone propionate) 25 mg. injected five times weekly for two weeks often proves the existence of the male climacteric while the patient benefits.[1]

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1. Heller, C. G., and Myers, G. B.: J.A.M.A. **126**:472, 1944.

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1. Virginia M. Monthly 72:240 (June) 1945.

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DISTRICT SOCIETY MEETINGS

continued from page 376

Dr. Alphonse R. Cardi then spoke briefly on his experiences, and described the chain of evacuation from the front lines to a general hospital. He described conditions and terrain in Normandy, where the many hedgerows acted both as a protection and also, at times, a site from which they were ambushed. He described the handling of combat exhaustion cases in aid stations, by rest, sedation and food with the result that about 50 per cent were able to resume duty.

The next speaker was Dr. Samuel D. Clark, who briefly described the mission in the C.B.I. theater (China, Burma, India). He pointed out that the chief purpose was to get supplies to China, and that the major effort to this end was the construction of the Ledo road. He described in interesting detail his experiences with the 45th portable surgical hospital, which consisted of thirty-four enlisted men and four officers. They were assigned to the 22nd Chinese division, and had to work under what may reasonably be described as primitive conditions. Although the official capacity of their hospital was twenty-five beds, it at times expanded to a patient-load of 175 patients, because of difficulties in evacuation. Dr. Clark ended his talk by showing several excellent kodochrome slides, illustrating his experiences during this period of service.

The next speaker was Dr. Nicholas A. Pournaras, who served with the 4th battalion of the 4th Marine division. This was an artillery outfit, and his experiences were chiefly in island hopping in the Pacific. He described, in some detail, the conditions and his experiences on Saipan and Iwo Jima. He told us that on Iwo Jima, there were approximately 80,000 soldiers compressed onto an island of approximately 8 square miles, so that a shell seldom went off without damaging someone.

The program was concluded by Dr. Guy W. Wells, who described the experiences of his hospital with hepatitis, both with and without jaundice. This caused a serious loss of manpower, the patients were often sick for many weeks and there was a significant mortality attached to the disease. The clinical and laboratory features of the disease were discussed, and the paramount importance of bed rest in the treatment was emphasized.

Attendance 108. The meeting adjourned at 10:30 p. m. Collation was served.

Respectfully submitted,

FRANK B. CUTTS, M.D.

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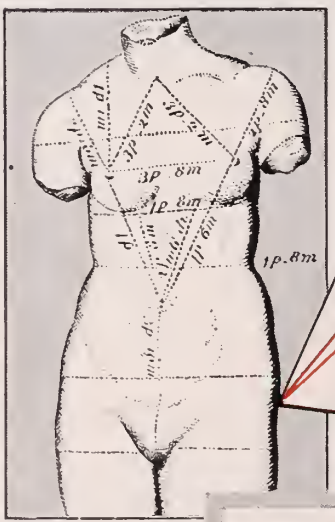
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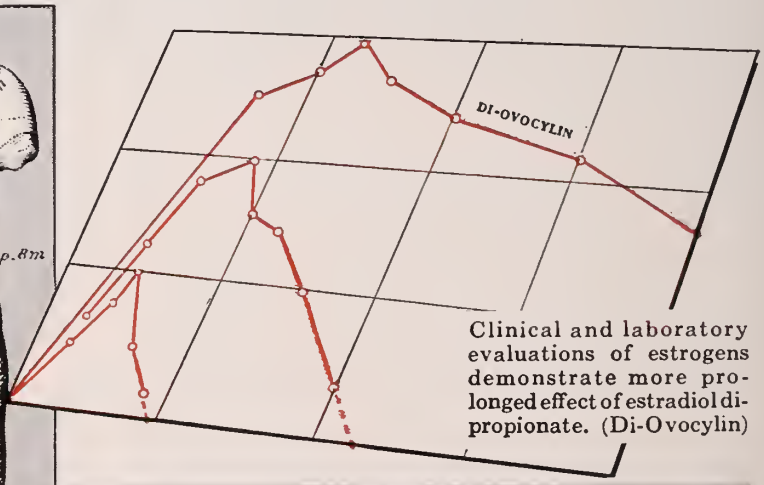
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*Greene, R. R.; Int. Abst. Surg. 74:595, 1942

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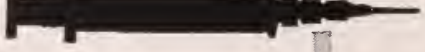




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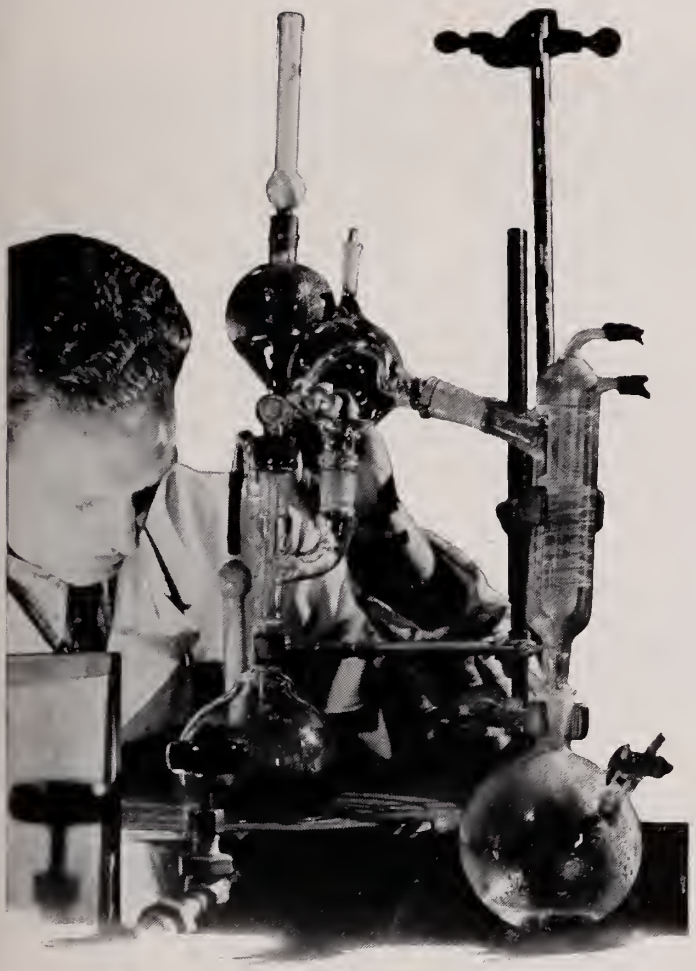
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COUNCIL OF THE NEW ENGLAND STATE MEDICAL SOCIETIES

Report of the Executive Secretary at the First Annual Meeting, Held at Boston, Massachusetts, April 17, 1946

THE Council of the New England State Medical Societies was organized at a meeting of representatives of the various medical societies held at Providence, Rhode Island, on July 18, 1945. The Council, approved by the six New England state medical societies, met in Conference at Providence again on October 14, 1945, informally at New Haven, Connecticut, on December 13, 1945, when the representatives were the guests of the Council of the Connecticut State Medical Society, and at Boston, Massachusetts, on February 3, 1946.

In this, its first year, the Council of the New England State Medical Societies has proved that it has great possibilities as a conference group to coordinate and to publicize the viewpoint of organized medicine in this part of the country. From many states have come inquiries about the Council, all of which is an indication of the interest that has already been created by it beyond our borders.

Members of the Council have individually done much to stimulate interest in New England medicine and in the significance of organized grouping such as we have achieved within the past year. The Vermont State Medical Society honored the executive secretary, and Dr. Leslie K. Sycamore of New Hampshire, with places on the speaking program of its annual meeting at Burlington in October. Drs. J. R. Miller, J. H. Howard, and C. B. Barker, and also the executive secretary, were guests of the New Jersey State Medical Society at a conference on legislation and welfare held at Trenton in October at which much interest was evoked in the Council of the New England state medical societies. Dr. Miller, president of the Council, was its representative at the annual meeting of the New England Council, of which we have become a member, at Boston in November. On the occasion of the second Annual Conference of Presidents and other officers of State Medical Societies, held in Chicago at the time of the special meeting of the House of Delegates of the American Medical Association, Dr. Joseph Howard, president of the Connecticut State Medical Society, and a member of this Council, delivered an outstanding address on voluntary prepayment insurance for medical care. And at the meeting of the House of Delegates of the A.M.A., New England, already honored by having Dr. Roger I. Lee as president of the national association, received additional prestige and honor as Dr. James R. Miller of Connecticut received the largest vote of any candidate in contest for a post as a member of the Board of Trustees of the American Medical Association.

Highlighting the activities of the Council has undoubtedly been the successful Conference on Medical Service and Public Relations held in Boston on Sunday, February 3, 1946. Co-operating with the Council of the American Medical Association our Council presented an excellent program which proved most enlightening to the large number of New England doctors in attendance. Subsequently, printed reports of the addresses and the discussion were sent to the secretary of each of the New England state medical societies for their local distribution, copies in quantity were furnished to the Council on Public Relations of the AMA for national distribution to public relations officers of state medical societies, a copy was sent to each secretary of the state medical societies throughout the country, and a copy was sent to the head of staff of each of the major hospitals in New England.

The problems incident to medical care for veterans has been discussed by the Council. A report of the meeting held by the Connecticut State Medical Society in September was sent to each representative. Our October meeting was productive of excellent discussion that undoubtedly aided each representative to understand the problem better. The executive secretary sent out a list of state commanders of the American Legion and of the Veterans of Foreign Wars to each New England state secretary with the suggestion that such authorities be contacted by medical groups.

The Council has sent to members copies of reprints on national legislative matters, particularly the much discussed Wagner act. These reprints included ones by the AMA, and local ones from the Rhode Island, New Hampshire and Connecticut medical societies. A list of the New England Congressional representation, with their addresses, was also compiled.

The executive secretary has also sent to members during the year copies of the workmen compensa-

continued on next page

tion laws of each of the New England states; a report on the New Hampshire Physicians' Service; the study report of the Rhode Island Medical Society on its proposed surgical insurance plan, and more recently the first of what is hoped may be a regular News Bulletin to members.

In March the executive secretary, together with Dr. O'Hara of Boston, met with Dr. Carl Peterson, secretary of the Council on Industrial Health of the American Medical Association, in Boston. The meeting was called by Dr. Peterson who invited leaders in industrial health in this area to discuss the possibility of holding the 7th Annual Industrial Health Conference in New England in the Fall of 1946. The Conference would be cosponsored by the Council of the New England State Medical Societies, and it is significant to note that it would make the first time this national meeting has been held out of Chicago.

We may take justifiable pride in the fact that one of our members, Dr. Joseph Howard, President of the Connecticut State Medical Society, has been one of the national medical leaders selected to appear before the Congressional Committee holding hearings of the Wagner Act.

Your executive secretary concludes this first annual report with two recommendations to the Council.

One recommendation is that the Council give strong support to the plan to hold the 7th Annual Industrial Health Congress in Boston, seeing in this Conference an outstanding opportunity to publicize medicine in New England, the truly great industrial area of the country. The Conference will bring with its scope representatives of industry and labor, as well as our physicians, and therefore it places the Council of the New England State Medical Societies in a fine position to publicize favorably medicine in general, and industrial medicine in particular.

Secondly, your secretary recommends consideration of the advisability of an official bulletin of the Council that would have wide distribution. The thought here is that too often, as was indicated to us by several physicians at the time of our Public Relations Conference, we point our information to those who presumably are the best informed on the very matters upon which we seek to educate. Your secretary recommends, therefore, consideration of a plan whereby an address file may be compiled of the president and the secretary, or any other proper officers, of each district medical society in New England, as well as the chief of staff of every hospital in this area. Then at regular intervals, as seems advisable, and as the information seems important, a Bulletin of four pages or more

continued on page 390

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White female, age 63. Marked desquamation of skin on both hands (4 months duration), chills, temperature 101.4 F., leukocyte count of 10,400, eosinophiles 4%, lymphangitis of upper extremities, left supraclavicular lymphadenitis.

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N. E. MEDICAL COUNCIL

continued from page 388

be sent to each listed physician to give him pertinent information of New England medical problems in particular, and national problems in general. Such a Bulletin would in no manner overlap or invade the work now done by any or all of the state medical journals published in New England. It would serve, on the contrary, as a supplement and as a clearing house of factual information or informative data that might be of invaluable assistance to the physician who knows too little of the complex problems of organized medicine. The cost of this Bulletin would depend, of course, on the circulation, size, and frequency of issue.

Respectfully submitted,

JOHN E. FARRELL, *Executive Secretary*

April 17, 1946

STATE HOSPITAL FOR MENTAL DISEASES

concluded from page 368

however, and it is anticipated that the State Hospital will continue to be one of the leading institutions of its type in the United States.

The State Hospital has had nine Medical Superintendents. They are listed below with their tenure of office.

GEORGE F. KEENE, M.D.—May 21, 1899 to March 13, 1905
FRED B. JEWETT, M.D.—June 16, 1906 to April 5, 1907
ARTHUR HARRINGTON, M.D.—Aug. 1, 1907 to Oct. 1, 1926
RANSOME H. SARTWELL, M.D.—Oct. 1, 1926 to Jan. 11, 1929
ARTHUR P. NOYES, M.D.—March 1, 1929 to June 5, 1936
SETH F. H. HOWES, M.D.—June 5, 1936 to July 1, 1939
CHARLES P. FITZPATRICK, M.D.—Aug. 1, 1939 to June 1, 1943
JOHN R. ROSS, M.D.—Aug. 1, 1943 to March 31, 1944
JOHN F. REGAN, M.D.—April 1, 1944 to present time

NEWS ITEMS

A course in Psychiatric Nursing for affiliate student nurses has been introduced at the State Hospital for Mental Diseases. The period of training covers thirteen weeks of didactic and practical work in Psychiatric Nursing. The first class was admitted September 3, 1945. The present class of nineteen student nurses represents the Homeopathic Hospital, St. Joseph Hospital, the Memorial Hospital, and the Newport Hospital nurses' training schools.

A Picker Minograph has been received and will be installed in the near future. 70mm. photofluoroscopic films will be taken of all employees and patients, to expand further the tuberculosis control program at the State Hospital.

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1 *Stare, F. J., and Thorn, G. W.: Protein Nutrition in Problems of Medical Interest, J.A.M.A. 127:1120 (April 28) 1945.*

2 *Stare, F. J., and Davidson, C. S.: Protein: Its Role in Human Nutrition; Introduction, J.A.M.A. 127:985 (April 14) 1945.*

3 *Anderson, G. K.: The Importance of Protein in Diet Therapy, J.Am.Dietet.A. 21:436 (July-August) 1945.*

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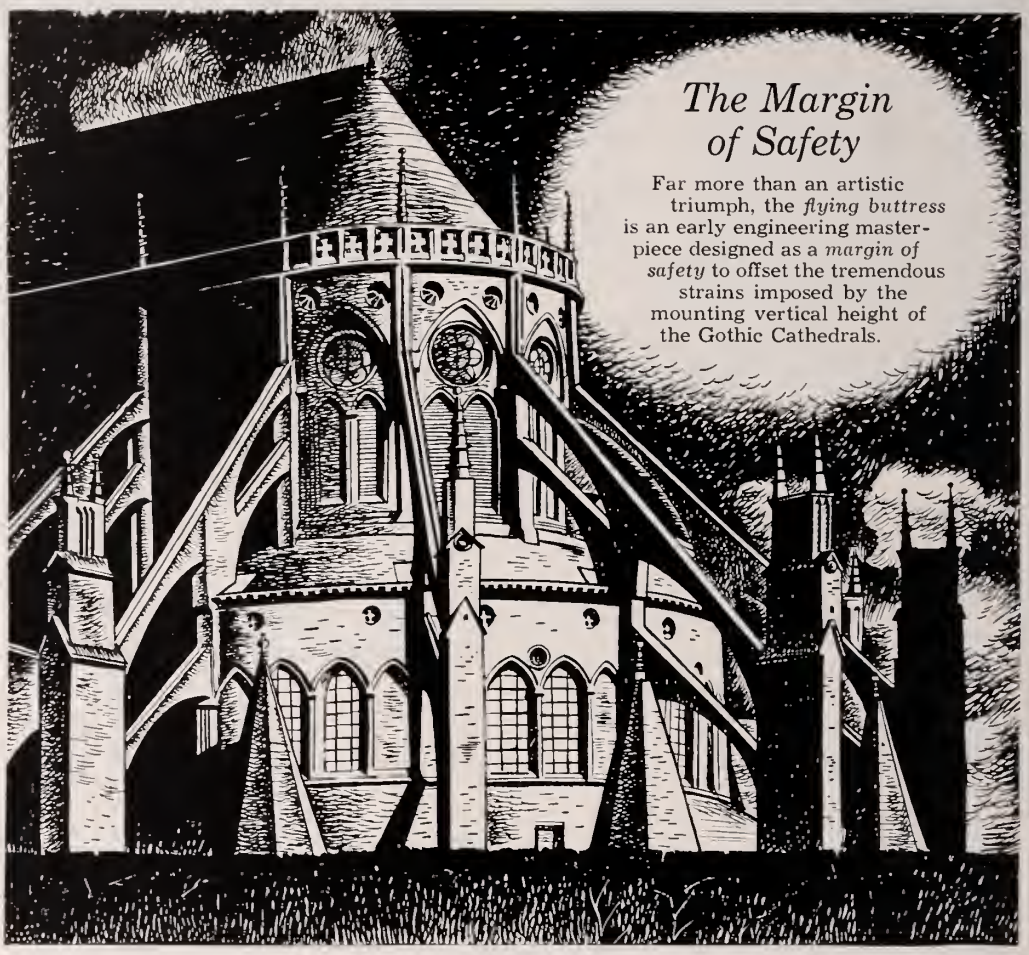


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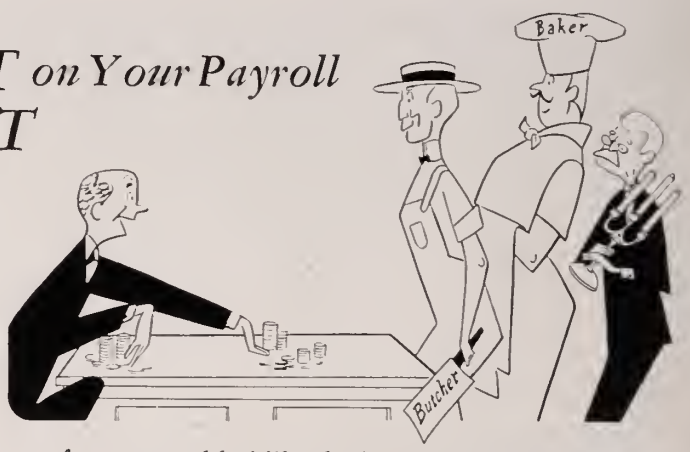
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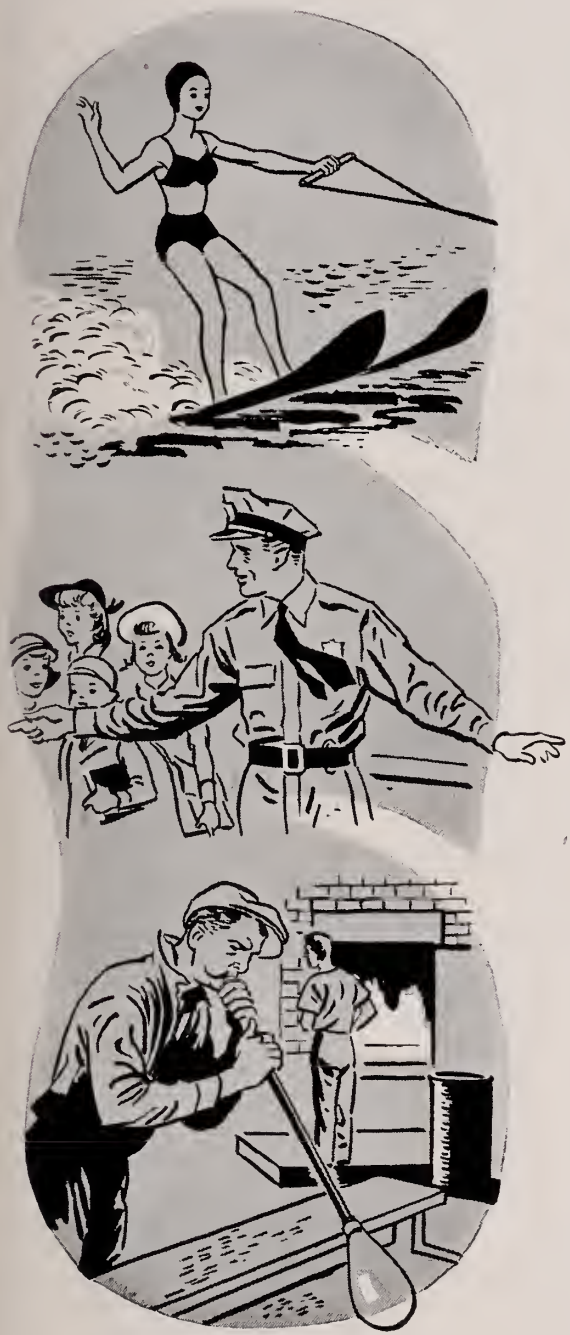
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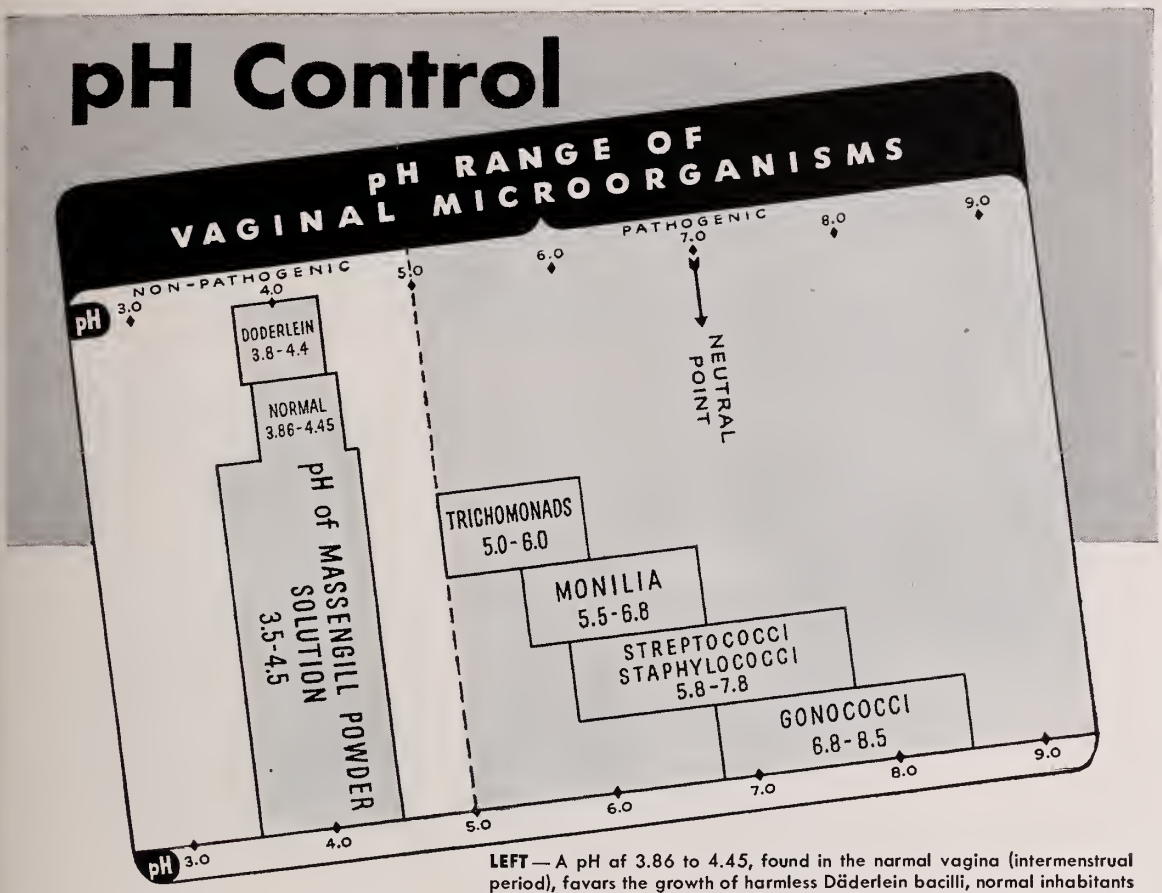
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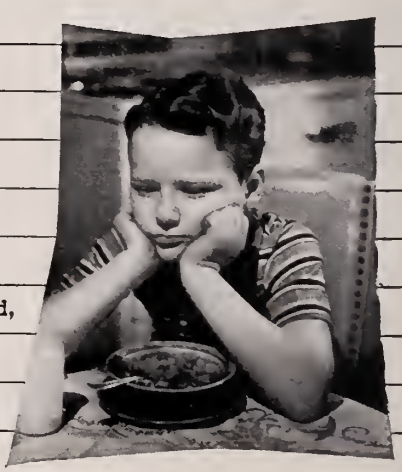
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WELCOME HOME

The Rhode Island Medical Society reports the following Rhode Island physicians as honorably released from active duty, most of whom have resumed the private practice of medicine in this State as of May 1. Additional listings will be made each month and members are urged to report promptly upon their return to Rhode Island.

IRVING BECK, M.D., 105 Keene Street, Providence
RAWSER P. CRANK, M.D., 794 Park Avenue, Cranston
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BANICE FEINBERG, M.D., 183 Angell Street, Providence
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EDMOND C. LAURELLI, M.D., 188 Main Street, Pawtucket
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BRADFORD M. S. PORTNOY, M.D., 672 Broad Street, Providence
RODRIGO P. C. REGO, M.D., 103 Governor Street, Providence
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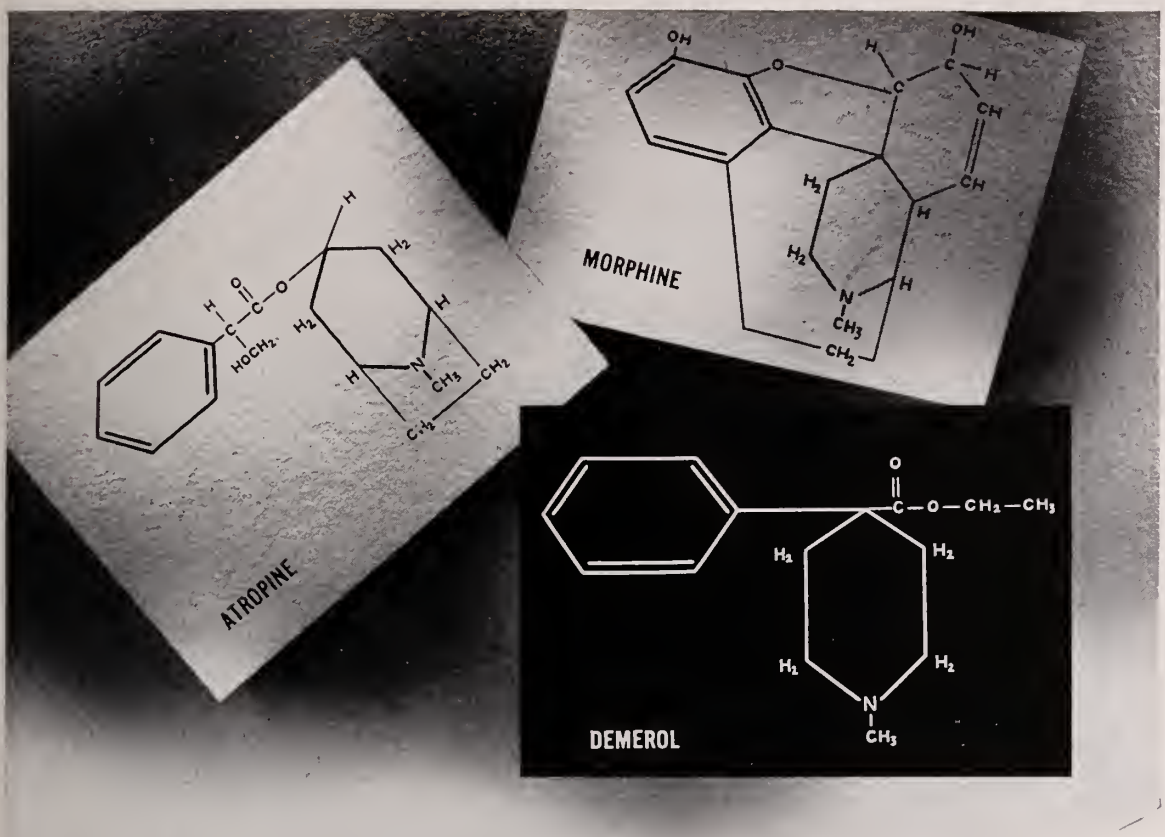
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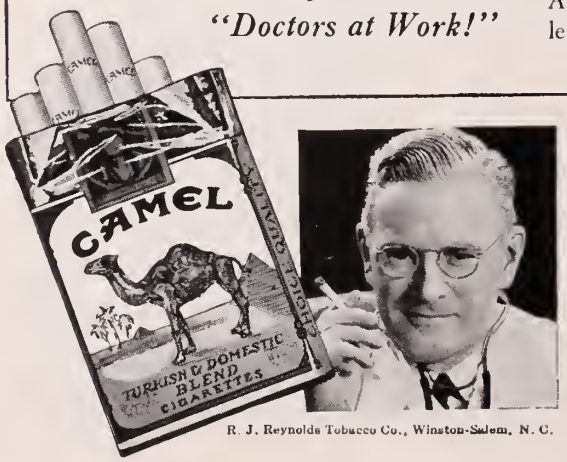


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Fifth Annual

CHARLES V. CHAPIN ORATION

"Recent Studies in the Prevention of Certain Infectious Diseases"

Page 423

THE RHODE ISLAND MEDICAL SOCIETY • HOSPITAL ASSOCIATION OF RHODE ISLAND

VOLUME XXIX, No. 6

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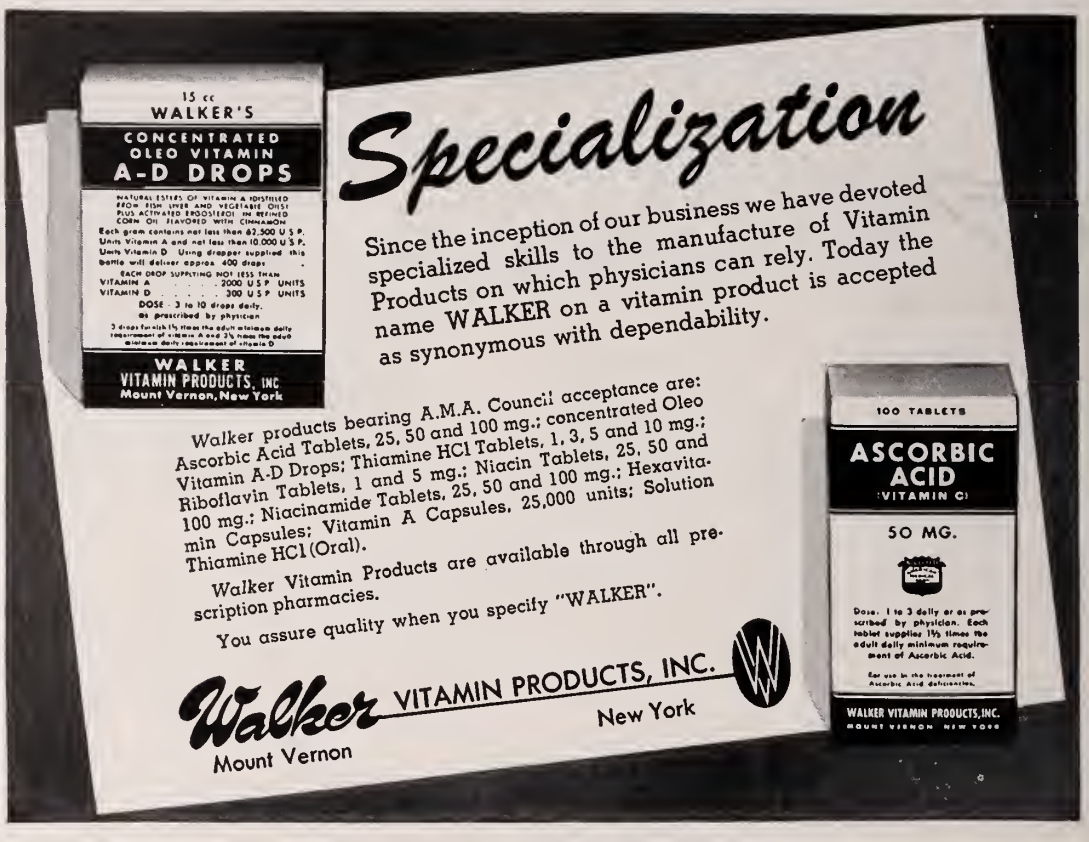
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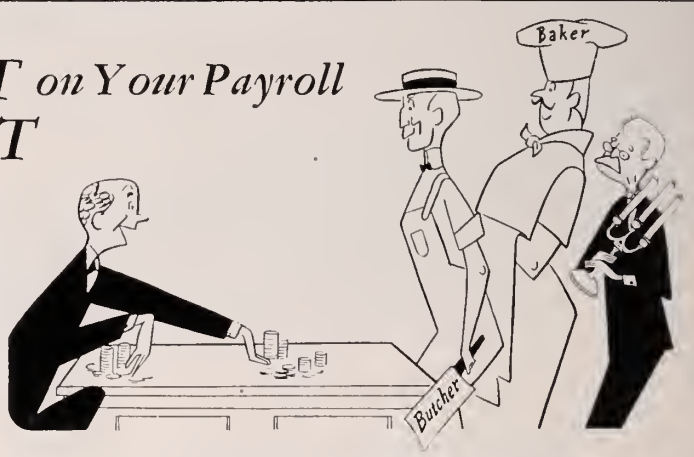
[1] *M. Rec.*, 158:420, 1945

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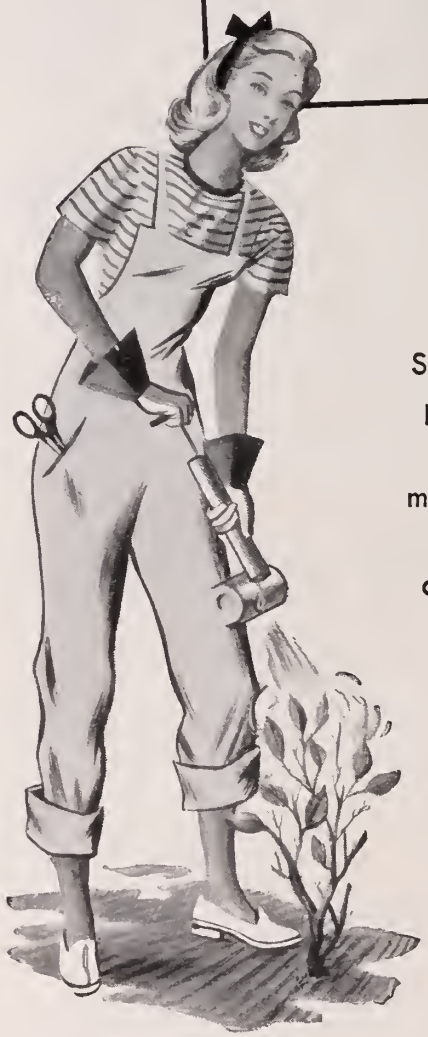
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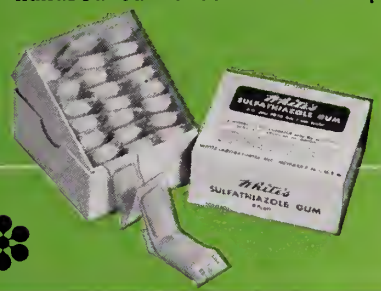
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*Strean, L.P. and Beaudet, J.P.: New York State J. Med., *45*:2183 (Oct. 15) 1945.

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The tempo of medical progress, always rapid, has been accelerated to a marked degree during the last few years. New discoveries and developments have been most revealing. In the practice of medicine, the old is never good enough if the new is better. Medical meetings are essential to better understanding, better health, and better medical care. The physician owes it to himself and to his patients to attend whenever possible.

A picture of The Good Samaritan provided the inspiration that



eventually led to the founding of Eli Lilly and Company

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXIX JUNE, 1946 NO. 6

The Fifth Annual Charles V. Chapin Oration

"RECENT STUDIES IN THE PREVENTION OF CERTAIN INFECTIOUS DISEASES"*

JOSEPH STOKES, JR., M.D.

The Author. *Joseph Stokes, Jr., M.D., of Philadelphia, Pennsylvania. William H. Bennett Professor of Pediatrics, School of Medicine, University of Pennsylvania.*

I WISH to express my deep appreciation for the honor of being asked to deliver the fifth Chapin Memorial Lecture before your Society. The war has emphasized with extraordinary clarity the importance in the field of medical research of a trait for which Dr. Chapin was particularly distinguished—good team work. After composing the larger portion of the present memorial lecture I remembered that Dr. Francis G. Blake had delivered the fourth memorial lecture last year and looked up his subject. He mentioned very graciously some of the work conducted by the Commission on Measles and Mumps under the Army Epidemiological Board over which he presided as President. No one had a better opportunity than Dr. Blake of viewing and evaluating the work on infectious diseases conducted by the armed services and in civilian institutions during this war nor has anyone given greater service in the development of a far-sighted program for their control in wartime. The team work for which Dr. Chapin was distinguished has been again memorialized in the data recorded here in his honor by Dr. Blake.

It is perhaps fitting therefore that the subjects I have chosen should be in the nature of a further supplement to much of the material he presented to the Society at that time. Some of the material will receive a more historical emphasis while the remaining portion will include one or two new subjects and the addition of data which were not available to him then. I trust you will excuse a brief review of some of his data for the purpose of preserving the continuity of their presentation.

* Presented at the 135th Annual Meeting of the Rhode Island Medical Society, at Providence, on May 15, 1946.

Like old McDougall, who in the nursery song owned a farm with a chick-chick here and a chick-chick there, here a chick, there a chick, everywhere a chick, the clinical investigator usually stakes out for himself far larger premises than he can possibly cover and in cultivating his chosen fields takes a poke-poke here and a poke-poke there, here a poke, there a poke, everywhere a poke with variable profit to all concerned. In investigations the clinician must necessarily take a poke here and a poke there as the opportunity arises, inasmuch as it is more difficult for him to limit himself to one field as is the proper course of the man who cultivates the more fundamental fields of medical science. In the clinician's position of exposure to interesting fields of medicine that impinge upon his curiosity with every new case he sees, the great danger is that he will dissipate his energies in the farmer McDougall sense of taking everywhere a poke. After all, the essential point for the clinician is to take a poke, at least, somewhere and in doing so, to learn how to confine his energies within the limits of his capabilities. Even investigators with the greatest ability and imagination fail of achievement when the imagination is undisciplined and lacks restricted objectives.

This evening I wish to review a group of studies from our laboratories of the University of Pennsylvania and the Children's Hospital of Philadelphia which have a certain continuity of outline and purpose. These studies are concerned with certain virus diseases and particularly with the application of practical methods for their control. Two of these diseases have been the most widespread and severe scourges of World War I and World War II. They are respectively pandemic influenza and pandemic hepatitis.

Two additional virus diseases which I want to discuss, measles and mumps also have played a large part in both wars, as well as occupying an important place in pediatric practice. For the pur-

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pose of holding to restricted objectives I shall outline only our own studies, mentioning but briefly those investigations from other laboratories which have a close practical bearing on the problems involved.

Epidemic and Pandemic Influenza

Two types of epidemic influenza thus far have been identified by means of determining their etiologic agents. These have been termed influenza A and B. Since the identification of the virus agent in 1933, epidemics of influenza A have appeared at approximately 2 to 3 yearly intervals while epidemics of influenza B have appeared at approximately 4 to 6 yearly intervals following its identification a few years later. Smith, Andrewes, and Laidlaw[1] were responsible for the identification of the influenza A virus, while Francis[2] and Magill[3] independently identified the influenza B virus. None of these epidemics has been particularly severe with the possible exception of the 1936-1937 influenza A epidemic, while in contrast pandemic influenza, such as that occurring in 1918, has been exceptionally severe and widespread. That pandemic influenza is related to influenza A has been frequently suggested, owing principally to the antigenic relation established by Shope[4] between the virus of swine influenza and influenza A virus and also to the fact that swine influenza apparently was noted for the first time during the 1918 pandemic of human influenza. It is conceivable however, that the great influenza pandemics which have swept through the world at intervals of two to three decades, have been due to more than a single etiologic agent, possibly to a compound virus and bacterial infection. With the recent discovery by the Doctors Henle,[5] working at the Children's Hospital of Philadelphia, that an endotoxin is present in the influenza virus particles themselves which varies considerably with different strains of both viruses A and B, it is also conceivable that the pandemic influenza is caused by a genetic alteration in the influenza virus A or B or in both resulting in a marked periodic increase in virulence.

If influenza A is related to pandemic influenza, which it probably is, then we appear to have developed over a period of years a means of vaccination which will at least partially control such pandemics.

Our studies beginning in 1935 early suggested that vaccination with active or inactivated preparations of influenza A virus was successful in protecting a large proportion of those vaccinated. One of the first such experiments conducted at the height of the influenza A epidemic of 1936-1937[6] was quite similar to those conducted more recently by the Army Epidemiological Board and afforded a similar type of protection in the vaccinated group against the epidemic disease. In this particular study at a large institution in New Jersey it was of interest that Shope[7] investigated the serum of swine in herds at "neighboring" institutions affected by the same epidemic wave and found that animals which had been present at the institutions during the epidemic of human influenza A showed marked increases in antibodies against the human influenza A virus and not against the swine influenza virus, although they had suffered no obvious illness. This finding and "our" isolation of the influenza A virus from human naso-pharyngeal washings of the unvaccinated group at the institution at different intervals during the epidemic afforded adequate evidence of the nature of this institutional outbreak, as caused by influenza A virus.

The findings at the University of Pennsylvania by Scott[8] that influenza virus could be obtained in very large amounts in the allantoic fluid of the developing chick embryo opened new possibilities for purification and concentration of virus for use as a vaccine or for the use of the formalized infected allantoic fluid as a vaccine without concentration.

Additional and conclusive evidence of the value of vaccination with influenza A virus against the disease was obtained by the group at the Children's Hospital of Philadelphia.[9] Volunteers, 44 in all, were vaccinated with formalized influenza A virus and they, together with a group of 28 unvaccinated control volunteers, were permitted to inhale active influenza A virus as a challenge to their immunity. The antibody content of the serum in these individuals was determined before and after vaccination and also following the challenge with active influenza A virus. The only vaccinated volunteer who developed influenza A as a result of the challenge was shown to have had no antibody response to the vaccine. Approximately one-third, or 10 of the 28 unvaccinated volunteers developed influenza A as a result of the challenge, a highly significant difference, particularly in view of the fact that in this group also influenza was limited to those individuals of low antibody titer. This study established in general a level of antibodies above which protection apparently was assured. A later experiment, of a similar type, by Francis,[10] confirmed the significance of these findings. He also expanded his studies to include groups of volunteers vaccinated with influenza B vaccine and later challenged with inhalation of active influenza B virus.[11] Significant protection was obtained also in this group.

During the recent war, in November and December of 1943, during a widespread epidemic of influenza A, and during the epidemic of influenza B

of the past winter, members of the Army Epidemiological Board's Commission on Influenza directed by Dr. Francis, have obtained conclusive data on the value of a combined vaccine of viruses A and B.[12] This vaccine is also obtained by concentrating the viruses from the allantoic fluid of the chick embryo by absorption on and elution of the viruses from chick red cells. Only a small part of this vaccine is influenza antigen owing to the admixture of extraneous chick material resulting from the method of production mentioned. Chambers and Henle at the University of Pennsylvania had previously used protamine for precipitation and concentration of the viruses,[13] while Stanley at the Rockefeller Institute, Princeton, more recently has used high-speed centrifugation by means of a Sharples centrifuge for such concentration,[14] both of which methods, for various reasons, appear preferable to the method used for the U. S. Army. Salk has also used Calcium Phosphate in precipitating the influenza viruses from allantoic fluid for the development of a similar vaccine.[15] This is also preferable to the vaccine used for the U. S. Army.

In adapting Freund's[16] use of a lanolin and mineral oil preparation for the slower absorption of parenterally injected antigens to the influenza virus, Friedewald of the Rockefeller Institute, New York, demonstrated in animals that vaccine of influenza viruses A and B in such an oily vehicle would produce excellent antibody responses over a longer period of time.[17] At The Children's Hospital of Philadelphia, studies chiefly by the Drs. Henle have confirmed these findings and extended them to man.[18] The use of such oily preparations of vaccine has resulted not only in a markedly increased height of antibody production but also in a greatly prolonged response which in the experiments now extended to over 18 months, has continued at a level of antibodies well above what may be considered the "protective level". A few local reactions at the site of injection have occurred, and two small abscesses have formed in a total of 80 individuals vaccinated. With modification to eliminate such reactions, if such modification is possible, this vaccine would appear to be one of the most promising steps in the efforts to protect large groups of the population against epidemic or even, perhaps, pandemic influenza.

It is also possible that unconcentrated or unmodified infected allantoic fluid containing viruses A and B, injected in a single dose of about 3 ml. at yearly intervals, on further study would prove to be the most practical and economical method of vaccination, despite the shorter period over which a "protective" level of antibodies is maintained. Epidemics are more apt to occur during the relatively short period of late fall to early spring.

I have reviewed a few of the steps in the development of influenza vaccine at this length, and this is actually but a brief and very incomplete review of the subject of influenza vaccine, to emphasize the inevitably slow steps the development in such a field requires, together with the close collaborative effort of the clinician and the virologist.

However great our progress may have been up to this moment, years of further study will be required for the establishment of the best methods and materials to protect against epidemic or pandemic influenza.

Inasmuch as some of the studies concerning the remaining subjects of hepatitis, measles, and mumps, and poliomyelitis are related to a fraction of pooled plasma, gamma globulin, it is essential that certain general concepts concerning the role of gamma globulin in infectious diseases should be considered.

It must be emphasized that the process of fractionation of gamma globulin not only separates but also concentrates the antibodies.[19] The concentration of antibodies in the gamma globulin thus prepared is approximately 25 times that of normal pooled plasma.[20]

The pooling of plasma from hundreds or thousands of adult blood donors, while only of quantitative value in the separation of such plasma components as albumin, may be, and usually is, of great qualitative value in respect to gamma globulin. The presence of antibodies against infectious diseases in human plasma appears to depend upon exposure to antigenic stimuli resulting both from subclinical or inapparent, and from clinical infections.

The large size of the plasma pools developed by the American Red Cross tends to assure a surprisingly uniform titer of antibodies against the infectious agents endemic to the geographic area in which the blood donors reside. In studies of gamma globulin obtained from donors in the eastern region of the United States, Dr. Werner Henle of the Children's Hospital, Philadelphia, found no detectable antibodies against Western equine encephalomyelitis virus, whereas antibodies against the Eastern equine encephalomyelitis virus were found in considerable amounts.[21] We are not aware of any evidence of the opposite picture in the gamma globulin obtained from Western donors, but it is probable that such a contrast will be found. Following the influenza A epidemic of November and December 1943 the gamma globulins from all areas of the United States gave evidence of a marked general increase in the antibodies against influenza A virus. As previously mentioned a direct relationship between the height of such antibodies and individual resistance to influenza A has been demonstrated by a number of workers, in-

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cluding out laboratories in Philadelphia.[9] Thus the general level of donors' antibodies in any population may provide an indication of its susceptibility to the epidemic disease as well as evidence of a recent epidemic wave of influenza. The uniformity of antibody levels in pooled plasma and thus in gamma globulin depends chiefly therefore upon the following factors:

1. The presence of endemic or of recent epidemic disease in the geographical area from which the blood is drawn.
2. The *amount* and the *duration* of antibodies resulting from specific infections.
3. The number of donors contributing to the pool.

Certain of these factors can be controlled in the collection of pooled plasma.

For a discussion of gamma globulin from pooled plasma it appears important to review some theoretical considerations relating to certain of the epidemic diseases of childhood caused by viruses, and also certain data recently accumulated concerning the possible uses of gamma globulin in such diseases.

The diseases chosen for this particular comparison are:—

1) Measles
2) Mumps
3) Infectious (epidemic) hepatitis
4) Poliomyelitis

Although not demonstrated conclusively in any of these 4 diseases it appears possible from the facts now available that either apparent or inapparent infection in childhood or early adult life with the 4 viruses effects a slowly developing permanent immunity to them in the greater part of the general population. Because of its ease of transmission, measles immunizes the general population earlier than the other 3 diseases. Infectious (epidemic) hepatitis appears to be the least readily transmissible (although it may be present at times in drinking water) of the four diseases and therefore may not immunize most of the population until the age range of approximately 30 to 35 years. Mumps and poliomyelitis would appear to occupy a position between measles and infectious hepatitis, depending upon the ease with which they are transmitted in varying aggregations of individuals. Thus, under usual conditions in the United States larger numbers of frank clinical cases of mumps and poliomyelitis occur among young adults than is the case with measles. The rapidity with which a population is immunized also obviously depends upon whether it is urban or rural. The unusual aggregations consequent to war-time conditions accelerate the immunization of persons from rural groups. The incidence of frank clinical cases of measles, mumps, infectious hepatitis, and poliomyelitis in the entire population diminshes in the order named. This order of incidence is not theoretical; the facts are well known. In contrast to the incidence of frank clinical cases, it appears possible (a theoretical possibility supported by considerable data) that the incidence of subclinical or inapparent infections increases, rather than diminishes, in the same order, measles having very few and poliomyelitis a great number of subclinical or inapparent cases. If most of the general population throughout its early years is permanently immunized against these infections by an interaction between host and parasite, regardless of whether the interaction is apparent or inapparent, then it is highly probable that the gamma globulin obtained from the general population in an age range above 30 years would contain antibodies in concentrated amounts against all of these diseases. These theoretical considerations have been strengthened by considerable experimental evidence.

Whether or not such concentrated antibodies are present and will passively protect against measles, mumps and infectious hepatitis has been studied in humans. Although no tests have been made in man due to war conditions, considerable evidence from studies of mice, cotton rats and monkeys indicates the presence in gamma globulin from human plasma pools of large amounts of antibodies against certain strains of poliomyelitis virus.

In passing from theory to practice the results of experimental study of these 4 diseases now may be considered.

Measles

In measles the data have been reviewed previously by a number of workers. Studies at the Children's Hospitals in Boston[22] and Philadelphia[23] have indicated that gamma globulin represents the most satisfactory biological as yet developed for passive protection of exposed susceptibles or for attenuation of the disease. The uniformity of antibodies demonstrated against other antigens than measles virus offers considerable assurance that the globulin in general has a constant titer of measles antibodies. The variables encountered in the clinical studies have been very few and in all probability have been associated with differing exposures and with a variation in host resistance.

Conclusive evidence concerning the value of gamma globulin in the treatment of early cases of measles must still await further studies although the data thus far obtained have suggested that the disease may be modified when large doses of globulin are administered in the prodromal stage of the disease, AT OR PREVIOUS to the appearance of Koplik spots.

Mumps

That the presence of considerable amounts of specific antibodies in pooled convalescent plasma or

in gamma globulin may not be sufficient to protect against certain virus diseases has been well demonstrated in the case of mumps in the experimental monkey by Dr. John Enders.[24] Following intraparotid injection of a mixture of equal parts of active mumps virus suspension and convalescent human serum only partial protection against parotitis in monkeys could be demonstrated. When gamma globulin derived from plasma obtained by Lt. Colonel Aims C. McGuinness from mumps convalescent cases was used in similar neutralization tests, somewhat more effective protection in monkeys against the disease was noted. Evidence of the comparative values of ordinary gamma globulin and of gamma globulin derived from the fractionation of convalescent plasma was obtained by Captain Sydney S. Gellis and Lt. Col. Aims C. McGuinness under the Commission on Measles and Mumps, Army Epidemiological Board.[25] Their data indicate that when 20 ml. of gamma globulin from convalescent pools were injected parenterally in the first twenty-four hours after the onset of epidemic parotitis a diminution in the incidence of orchitis to less than 7% occurred, while no effect was obtained from the parenteral injection of 50 ml. of ordinary gamma globulin. In all large outbreaks of mumps in the U. S. Army as well as in the units studied, the incidence of orchitis has approximated 27 to 33 per cent, thus indicating that the protection afforded by the gamma globulin from convalescent plasma was apparently not a chance occurrence, but was a result of the injected material. This difference obtained in the two groups is statistically significant. The obvious conclusion is that the protective antibodies must be administered in considerable amounts to be effective.

It remains to be determined whether or not the titer of complement fixing antibody which was considerably greater in the gamma globulin from convalescent plasma (Enders) is an index of the protective value of the material.

Although insufficient evidence is available, apparently gamma globulin from plasma pools derived from the general population is not usually effective in protecting exposed susceptibles against mumps in amounts up to 50 ml. Considerable amounts of complement fixing antibodies in the pooled plasma of the general adult population from whom the blood is drawn and thus in the gamma globulin emphasize the finding of Drs. Enders and Kane in Boston, together with Drs. Maris and Stokes in Philadelphia, that when an epidemic of mumps sweeps through a group of susceptibles in a children's institution, in addition to those who contract frank clinical cases, there is also a considerable group of susceptibles who suffer inapparent or subclinical infections. The latter group develops complement fixing antibodies and positive skin tests to heated mumps virus for the first time as a result of such inapparent infections and apparently is immunized following such exposure. It is reasonable to suppose that in this manner most of the susceptibles gradually disappear throughout early life as a result of repeated exposures, whether or not they suffer from frank clinical mumps, and in a reciprocal manner, antibodies appear in the general population.

The value of gamma globulin in mumps thus appears to depend upon facilities for the pooling and fractionation of large amounts of convalescent plasma. In time of peace only moderate amounts of convalescent plasma would be available. If this could be obtained, which seems problematical, it should probably be reserved for treatment of adult males in the first 24 hours of their disease with the aim of preventing or attenuating acute orchitis. The equivalent amount of pooled convalescent plasma injected intravenously should be equally effective but is not as readily preserved as the gamma globulin due to required storage facilities and deterioration. Also the risk of producing serum hepatitis apparently is absent in the case of gamma globulin.

Infectious (Epidemic) Hepatitis

In measles and mumps, one is dealing with virus agents which can at least be studied in monkeys, if not in other animals. Such is not the case in infectious (epidemic) hepatitis, since no susceptible animal has been found. Also in measles and mumps there appear to be few differences in the antigenic properties of their respective viruses inasmuch as one attack usually confers a permanent immunity against all other epidemic strains of virus. Due to the low incidence of frank cases of

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Joseph Stokes, Jr. M.D., of Philadelphia, (left) receives the Dr. Charles V. Chapin Medal Award from Mayor Dennis J. Roberts of Providence at the 135th Annual meeting of the Rhode Island Medical Society.

infectious (epidemic) hepatitis during times of peace, adequate data concerning the antigenic relation of epidemic strains are lacking. Also the virus agent or agents responsible for homologous serum hepatitis may or may not have an antigenic relationship to infectious (epidemic) hepatitis.[26]

In infectious (epidemic) hepatitis the incidence rapidly decreases after the age of 30 years, whereas the inconclusive evidence thus far available does not indicate a similar tendency in serum hepatitis. As previously mentioned, a general immunization of the population during the early years apparently occurs in infectious (epidemic) hepatitis, whereas this may not occur in serum hepatitis. If this occurred in serum hepatitis it would be more difficult to explain the hepatitis resulting from the use of the plasma pools in battle casualties.

The presence of antibodies cannot readily be determined by serological means, as in mumps, and thus one can only infer from epidemiologic evidence and from the protective effect of the gamma globulin[27] (see below) that a major portion of the general population is immunized during the early years of life from apparent or inapparent infection with the virus of infectious (epidemic) hepatitis. The experience during the recent war period with different epidemics of infectious (epidemic) hepatitis suggests that clinical cases without jaundice may be nearly as frequent as those with jaundice (Ref. to Akiba epidemic).

Protection "was" afforded against infectious (epidemic) hepatitis by a dose of 10 ml. of gamma globulin in certain units of the 5th Army during the fall and winter of 1944 to 1945. Further epidemic studies made by Capt. Neefe,[27] Capt. Gellis[28] and myself, two in the Mediterranean Theatre of Operations and one in the United States, have demonstrated even more strikingly the value of gamma globulin for passive immunization in this disease. Major Havens and Dr. Paul of New Haven[29] have reported a similarly favorable result. The protection afforded appears to be effective for a period of from six to eight weeks, inasmuch as the long incubation period offers a more adequate opportunity for passive protection than in such a disease as measles.

The protective dosage has been demonstrated to be as small as approximately .06 ml. per pound of body weight, and may prove to be even smaller.

In contrast to the value of gamma globulin in prevention of infectious (epidemic) hepatitis, no value in treatment of the active disease could be demonstrated in limited studies conducted with Captain Gellis in the Mediterranean Theatre[28] during the autumn and winter of 1944 to 1945. These studies were not sufficient to be conclusive and it was possible to treat only a few cases within the first few days of onset. Treatment of infectious (epidemic) hepatitis with gamma globulin deserves further trial.

The value of gamma globulin in the prevention of serum hepatitis remains an interesting problem. Studies were initiated in two large general hospitals in this country among battle casualties who had received blood or plasma or both at the time of injury in various theatres of war. In one hospital[30] in which alternate casualties were injected with gamma globulin—10 ml. in a single dose—the incidence of hepatitis in the injected group did not differ significantly from the incidence of the disease in the controls. However, the average incubation period in the injected group was significantly longer than the average incubation period in the controls. The chance of this average delay in the incubation period not being due to the injection of the globulin was calculated as approximately one in four hundred. In another general hospital[31] which suffered a considerably higher incidence of serum hepatitis, alternate casualties were injected with 2 doses of 10 ml. each of gamma globulin at an interval of 30 days. The use of 2 doses appeared to be considerably more successful than a single dose in that the raio of cases of hepatitis in the control group to cases in the injected group was as seven to one. The chance distribution of the alternate cases in this hospital was indicated by the fact that the various percentages of casualties from the three different theatres of war—European, Mediterranean, and Pacific—were almost identical in the injected and control groups. The only additional general hospital from which data have been obtained as to the results of a single injection of gamma globulin, 10 ml. in all transfused battle casualties reported that the average incubation period of all cases of serum hepatitis was considerably increased over the average incubation period in those cases which occurred before the use of gamma globulin was started. Such data are difficult to evaluate until there is an opportunity of studying further the effect of multiple or larger doses of the globulin in controlling the disease.

In view of the fact that the incidence of infectious (epidemic) hepatitis falls off rapidly after approximately 30 years of age and that no such change has been demonstrated in serum hepatitis, it is difficult to believe that gamma globulin from large pools of adult plasma would be as effective in serum hepatitis as in epidemic or infectious hepatitis.

Poliomyelitis

When gamma globulin from the American Red Cross pools became available, Dr. Sydney Kramer at Michigan, and Dr. Werner Henle and I in Phila-

delphia were all equally interested in determining the presence of neutralizing antibodies against the Lansing strain of poliomyelitis virus. Neutralization tests were conducted in both laboratories when the material first became available and the presence of large amounts of such antibodies was demonstrated. It also became apparent that a very small amount of gamma globulin, 0.1 ml. injected intraperitoneally, would usually protect a mouse, even when the virus was injected intracerebrally at the same time. Further studies conducted by Kramer in cotton rats and monkeys have confirmed its protective value in these animals similar to that originally demonstrated in mice.

The interest in these findings lies not so much in their practical application, which appears highly problematical in view of the low incidence of the disease in man, but rather in the fact that despite the low incidence of the clinical disease, the relatively large amounts of antibodies present would suggest an immunization of the general population, which could perhaps best be explained by subclinical or inapparent infections. This also confirms earlier antibody studies by Kramer[32] and Aycock.[33] There are obviously other possible explanations which in view of the present findings appear less plausible.

Due to the expensive and time-consuming neutralization test in mice, cotton rats, or monkeys, and the variation in virus strains one can only infer, as in infectious hepatitis, on epidemiologic evidence and from the protective effect of the gamma globulin that immunization of a major portion of the general population occurs during the early years of life from mild clinical or subclinical (inapparent) infections. In poliomyelitis this point remains of major importance for investigation, namely, to determine at what age in different geographical areas antibodies appear in groups of children studied longitudinally and both individually and collectively.

In animals, treatment with gamma globulin has proven totally ineffective and injection of large amounts of gamma globulin during the incubation period even well in advance of the earliest onset of the disease has not appeared to decrease its severity when the virus is injected intracerebrally.

During a recent severe epidemic of poliomyelitis Bahlke[34] and Perkins of the New York State Department of Health demonstrated that large doses of gamma globulin injected parenterally as treatment in alternate preparalytic cases had no effect on the course or outcome of the disease.

The use of large amounts of gamma globulin for the study of passive protection of animals infected by more natural routes deserves continued investigation.

Rubella

Due particularly to the serious consequences to the fetus often attendant upon rubella in the mother during early pregnancy, as first reported from Australia by N. M. Gregg[35] and confirmed by many other workers, passive protection against this disease in the pregnant woman assumes an added significance. In 1943 and 1944 two experiments on rubella were conducted in Philadelphia, one at the University of Pennsylvania Hospital and one with Dr. Waldo Nelson at Temple University Hospital. In the first study, a nurse with rubella intimately exposed 5 room-mates who had no history of the disease. No secondary cases developed following the injection of 5 ml. of gamma globulin 4 days after exposure in each of the presumably susceptible adults. In the second study, an infant with rubella intimately exposed to the disease a ward of 13 infants and children who were presumably susceptible. No secondary cases developed following the injection of 2 ml. of gamma globulin 4 days after exposure. These results are recorded only for the purpose of suggesting the need for additional studies in this field. As in the other diseases, mentioned, the major portion of the population appears to be immunized in early life.

In pursuing a thesis such as this concerning a number of infectious diseases one may tend to oversimplify the problems involved. It must be remembered that although in measles there may be few or only slight antigenic differences in the causative viruses, this is not true in either influenza A or B, nor is it true in poliomyelitis. The pooling of a large number of plasmas would possibly permit the "coverage" by antibodies of many strains of a single type of virus, but such "coverage" must be determined experimentally. Also, the small amount of protective antibodies in convalescent mumps plasma has been pointed out and our experiments with Dr. Enders have indicated that many individuals are immune despite a lack of measurable antibodies in their plasma. When heated antigen is injected intradermally in such immunes, an immediate recall of antibodies in the plasma occurs; a fact which is not characteristic of the susceptible. This illustrates the importance of tissue or cellular immunity entirely aside from circulating antibodies, and tissue or cell resistance in mumps may possibly be more important than circulating antibodies. We do not know the relative importance of tissue immunity and circulating antibodies in poliomyelitis.

In diseases, however, in which the virus circulates through the blood stream during the early stages, gamma globulin may be far more effective. During the past winter, in conjunction with Dr. Gellis, it was found that 5 ml. of gamma globulin injected parenterally did not protect children

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against influenza B. For this disease amounts of globulin may be necessary, which would alter considerably the total level of plasma antibodies and be reflected in the antibody level of secretions of the respiratory tract. Antibodies in globulin from pooled plasma would be useful for following epidemic trends in influenza but of little use in a disease such as mumps.

Conclusions

1) Vaccination against influenza A. & B. appears to be increasingly successful, but a considerable period of time will be required before the best methods of active immunization have been attained.
2) Many epidemic diseases of childhood gradually immunize the general population both by apparent and inapparent cases and leave in passage considerable amounts of antibodies in adult plasma.
3) When such adult plasma is pooled from thousands of individuals it probably contains fairly uniform titers of antibodies, the changes in which, if readily measurable, afford an index of epidemic trends in certain diseases.
4) Gamma globulin from fractionated pools of plasma concentrates and preserves such antibodies in a readily usable form, which thus far apparently has been free from the danger of serum hepatitis.
5) The amount of specific protective antibodies in the gamma globulin and their effectiveness against each epidemic disease obviously differs and must be determined in each disease. In certain epidemic diseases outlined, they are highly effective.

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THE FUTURE OF MEDICINE*

JOHN F. KENNEY, M.D.

The Author. *John F. Kenney, M.D., of Pawtucket, R. I. President, Rhode Island Medical Society, 1945-46; Chief, Medical Division and Director of the Laboratory, Memorial Hospital, Pawtucket, R. I.; President, New England Conference, American Association of Industrial Physicians.*

TODAY it is my responsibility as retiring President to give an account of my stewardship for my tenure of office from May, 1945, until May, 1946.

If you have been following the reports from time to time in the RHODE ISLAND MEDICAL JOURNAL, and yes, even in the daily newspapers, you are aware of the fact that it has been a very busy year.

At the outset let me thank the Officers, the members of the Council and of the House of Delegates, the many Fellows of the Society serving on the various committees, and also our executive secretary whose enthusiasm and work goes far beyond the limits called for in his position. It is with these members that I have been able to carry on, and particularly in the last quarter of my term when I was incapacitated.

In my induction message last year I said it was to be a year of medical economics, which it proved to be, necessitating more than the usual number of meetings of the Council, the House of Delegates, and the various committees to take up such subjects as the vocational rehabilitation program, both civilian and veteran, the amending of the state cash sickness compensation law as regards the medical phases of it, meetings with leaders of industry and insurance to consider the medical problems of the workmen's compensation program, the study of a voluntary prepaid surgical insurance plan, and other equally important matters. Many of the meetings were initiated by non-medical groups, and the Society was most willing to cooperate in the discussion of possible improvements in any programs involving the medical care of the public generally.

Your President, representing the Society, addressed a number of large organizations, including the Connecticut State Medical Society and the New England meeting of the Industrial Nurses' Association.

Two outstanding accomplishments were the formation of the Council of the New England State Medical Societies, and the development of a plan for voluntary prepaid surgical insurance in Rhode Island. The New England medical council was suggested by Dr. Michael H. Sullivan, a former President of our Society, and it was furthered by my immediate predecessor, Dr. Elihu S. Wing. The first and second meetings of this new Council were held in Providence and were enthusiastically attended by representatives from each of the New England state societies. In its first year this Council has accomplished considerable and it is my firm belief that if this and similar organizations formed on a regional basis had been started a few years ago so-called state medicine would have made little headway.

The prepaid voluntary surgical insurance program has become a reality after considerable work by the study committee and by the House of Delegates. We are proceeding carefully in developing the program, and it is my belief that the surest way to start a good plan is not to rush forward with an inefficient, unworkable program that will have to be amended radically, or discarded, within a short time. Therefore I recommend continued careful study and planning to any and all such plans before launching them upon the public.

What about the future of medicine?

All we need to insure good medical care in the future is to educate the general public as well, or better, than the forces already at work who paint the picture so bright describing what they think the public wants or what the government should give them that they would have us believe that we will live in a "Shangri-La." These forces have used all such media as the newspaper, radio, motion pictures, public speakers, etc., and they are always ready to address any group, large or small, but always with publicity for themselves. We have right on our side and we have proved to the world that here in America we have, and have had, the best medical care in the world. The Profession has been satisfied to stand by and to point to its results, but our trouble has been that we have not turned the spotlight on our efforts, nor "beat the drums"

* Presidential Address delivered before the 135th Annual Meeting of the Rhode Island Medical Society, at Providence, May 16, 1946.

loud enough to awaken the public to the achievements of medicine in this country. The groups who advocate a change in the pattern of American Medicine take advantage of our failure in this respect, and though they are in a minority, they are well organized for their task.

Groups of medical men, both general practitioners and specialists, dentists, hospitals, nurses, and pharmacists should concentrate on a definite plan, as the services of all will be affected if this minority has its way.

Who among the physicians of this state, having explained to a patient exactly what the new concept of medical care would be, would receive the answer that state controlled medical care in any form is preferable? That is why I stress the need for education on the part of the public and, if carried out successfully no physician or group of physicians will ever have to interview or attempt to sway any legislative body to protect the health of the public.

With this in mind let me speak of two organizations that I hope will soon come into being and you will see how they would work along the lines of education as to what medicine has already done and what may be necessary in the future.

First, the Women's Auxiliary to the Rhode Island Medical Society, for which the House of Delegates last week authorized the appointment of a committee to initiate an organization meeting. Such an organization, developed along lines approved by the American Medical Association, and already in existence in forty-two states, should prove a valuable affiliate to our historic Society. Secondly, a statewide health council of professional men and laymen to consider all matters of health throughout Rhode Island. Your Council has already approved of the appointment of a committee to consider the feasibility of such an organization along lines advocated by Dr. Emery M. Porter and Dr. Elihu S. Wing.

We can all agree, both medical and lay persons, that times are changing. Our various medical groups are trying to meet that change, but first and last we must all think in terms of what will be the final result in the care and well-being of the patient, both from a health and financial standpoint. We must not think in terms of how many dollars and cents the federal government will spend, or how comfortable it will be for the physician to practice under state control. Both you and I can prove beyond a doubt that any system of state control put forth so far by the government planners will result in a setback for proper patient medical care for many years to come.

Looking to the future we may continue to have the best health of any country in the world, and under our non-government control we will go on improving our various postgraduate and specialty programs, setting high standards for hospital practice, and increasing the requirements for excellence in educational training as a prerequisite for licensure. On the other hand, under government control we would find the same high ideals and standards attempted by a group of high type medical men whose vocation to medicine, and love of their fellowman, were the incentives to enter the profession. But later the efforts of these physicians would be replaced by politically-minded individuals whose principles will not be concerned with the best care for the patient, or continued study in medicine, but rather the desire to improve their position by currying the favor of the political powers administering the medical and health programs.

No honest man can deny that the type of man entering medical service under the government system as proposed in compulsory health legislation will be the same high type of man that now, or in the past, entered the profession. True, none of this change would happen overnight, but we would certainly see a continual and gradual breaking down of all standards of the medical profession as we now recognize it, as well as those of the hospitals and the medical schools.

I conclude by repeating to you my belief that the decision is yours, gentlemen; for I am sure that no reasonable citizen of this state will accept any lowering of the medical care for himself or his family, and it is up to you to show him clearly just what he would really receive under a compulsory federal plan.



Dr. John F. Kenney, of Pawtucket, retiring President of the Rhode Island Medical Society, turns over the gavel to his successor, Dr. Herman C. Pitts, of Providence.

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NARRAGANSETT BAY

We print in this number the report of the Committee on Water Pollution made at the last meeting of the Providence Medical Association. That this is a matter of great interest to the general public is evidenced by the prominence given it by the Providence *Journal* and *Bulletin.*

If there is such a thing as an axiom, we think it can be taken for granted that Narragansett Bay is a nasty place. Waste products from innumerable manufacturing plants pour into it, oil from many sources shows its presence by greasing the shores and the hulls of crafts on its waters and by killing the wild fowl that frequent it. And most revolting of all, raw sewage from communities of many thousands of human beings is dumped into it continuously. When Roger Williams landed here, it must have been one of nature's fairest spots. Jean Valjean who swam the sewers of Paris would now hesitate to dive into the upper bay.

The part of the report that occasioned the most public discussion dealt with the danger of contaminated shell fish. Many recent stories in the public press regarding the "bootlegging" of quahaugs make it reasonably certain that these bivalves taken wherever they may be found have been sold in not inconsiderable numbers. At least one professional quahauger was quoted in the daily paper as using "rule of thumb" methods to determine the healthfulness of his product. Our sympathy goes out to the organized shellfish industry. They have been great sufferers from the increased pollution, and no one doubts their earnest desire for improvement. We are sure they are doing their utmost for a clean product.

But what definite information have they and the public regarding the water conditions below Conimicut Point? According to a report to the State Planning Board of 1940, "there has been a continuous expansion of the contaminated region of the upper bay, accompanied by a transformation of the once clean bottom to a foul-smelling mud unfit for normal marine life of any sort. The range of foul bottom extends in places far beyond the restricted water zone." Does anyone suppose conditions have improved with the increased industry of the war years? Crooks in this country are presumed to be as innocent as Sunday School superintendents until proved guilty beyond doubt. We have been told that in France they are guilty until they have established their innocence. In all health problems the French method should be used. The waters of our bay are under grave suspicion. We think that frequent reports with figures should be published as in the case of our excellent milk sup-

continued on next page

plies. When our high spring tides have pushed up to Crawford Street and Red Bridge and then have flowed swiftly down to the lower bay, frequent examinations at the end of the ebb should be made and reported. No one would be more gratified than the medical profession to receive good reports. But our shellfish beds should be like Caesar's wife.

The danger to our sea-food supplies is not the only problem, or even the greatest, that confronts us. After all, we can get fish and shellfish from other places. The recreational and health-giving opportunities that our naturally beautiful bay should provide for this great population can be used only if they are near at hand. The privileged few can ignore this contaminated cesspool and hie themselves to the clean mountains and shores of Cape Cod and Maine. The great mass of our inhabitants must be able to take a few hours off for smoke-free air, clean water and a handsome countryside, or they will have to do without them. And Providence is notoriously unprovided with even the help of an adequate park system. Disinterested citizens did much work a few years ago in the hopes of improving this disgusting situation. But the project died aborning. The difficulties probably seemed insurmountable. Industry undoubtedly wished to cooperate, but the costs were enormous and why clean up when communities "corrupt and contented" continue to dump their sewage into the streams?

Now the war is over we trust that courage will be revived and another effort made. A medical profession not called upon for help before will gladly do their humble part now.

DR. BUFFUM RETIRES AS SECRETARY

Coincident with the 1946 Meeting of the Rhode Island Medical Society Dr. William P. Buffum of Providence retired from the position of Secretary of this organization after 5 years of outstanding service. Dr. Buffum's energy and ability have stimulated his colleagues for many years in numerous activities, and his influence as Secretary of our State Society during this term which has overlapped the strenuous war years has been great. Conscientious participation in the activities of a medical society, either as an officer or a committee member, calls for hard work, the expenditure of much time, and, as any physician who has served in such a capacity at any time knows, there is frequently little apparent appreciation or thanks from those who have received the greatest benefit. For years Dr. Buffum has served on a great variety of committees, not only in our State Society but also in other medical organizations, and his reputation for getting things done efficiently and graciously is well known to all who have worked with him. Among Dr. Buffum's many other activities were his Presidency of the Providence Medical Association in 1935, his present positions as Chief of the Pediatric Service and President of the Staff of the Rhode Island Hospital, and his recently assumed responsibility as State Chairman for Rhode Island of the American Academy of Pediatrics, which is at present sponsoring a nation-wide survey of child health services. We are grateful to Dr. Buffum for what he has done for the Rhode Island Medical Society for many years and particularly so for his invigorating occupany of the position of Secretary, 1941-1946.

HEALTH FUNDS

Governor Pastore in his graceful and pertinent talk at the annual meeting of the Rhode Island Medical Society suggested the possibility of diverting some of the funds of the Infantile Paralysis Foundation to the rheumatic fever campaign. In the light of what has been emphasized by a recent series of articles in the Providence *Journal-Bulletin* this matter warrants serious consideration. The American public is prone at times to let its heart run away with its head. Here we have a case in point. Even the bitter political opponents of the late President Roosevelt would have to admit that the manner in which he met and triumphed over the terrible calamity of his paralysis was an inspiring example of courage and perseverance. With his name and association to support them enthusiasts developed this organization to fight poliomyelitis and started one of the most successful campaigns in our history to raise funds.

This is highly laudable and worthwhile. But in their zeal they forgot the doctrine of the greatest good to the greatest number, an abstract proposition never arousing the sympathy that concrete cases do. There are a comparatively small number of victims of infantile paralysis. The sufferers from cancer and rheumatic heart disease are tremendous in number. There is a terrifying vividness when a fine specimen of humanity is suddenly stricken by polio, but, as Governor Pastore pointed out, although this is visible it is no more real and often less of a hardship than the diseased heart.

We think Governor Pastore's view of this whole matter is a broad one and we trust that some definite and constructive action may follow.

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R. I. HOSPITAL ESTABLISHES INSTITUTE OF PATHOLOGY

OFFERING pathological and clinical laboratory services to other, and especially smaller, hospitals throughout the state, the Rhode Island Hospital has established an Institute of Pathology.

The hospital's board of trustees, with the cooperation of the medical staff, has made possible the development of this Institute of Pathology, the details of which have been developed by B. Earl Clarke, M.D., director of the hospital's department of pathology, and Oliver G. Pratt, executive director of the hospital. It was felt that the organization of a centralized Institute of Pathology offers distinct advantages to medical and hospital organizations throughout the entire state, especially to those smaller ones that cannot by themselves attract or maintain the high caliber of specialized staff necessary to modern scientific pathologic techniques, and that lack the highly specialized equipment and facilities on which pathologic science is dependent.

The initial program offered to hospitals now participating in the plan includes:

1. Attendance of an Institute pathologist at clinical-pathologic conferences, tumor clinics and any other such scientific meetings as those hospitals participating in the plan may wish to arrange through their own medical staffs.

2. The daily processing of surgical specimens with complete pathologic reports. The installation of a new autotechnicon has greatly speeded up this service.

3. A detailed service, by appointment, for immediate pathological study, with frozen sections if necessary, at time of operation in cases suspected to have cancer, as arrangements are made by participating hospitals in accordance with their particularized needs.

4. The performance of autopsies in the pathological departments of the affiliated hospitals with processing of microscopic preparations from autopsy material at the Institute.

5. A carefully planned system of resident, refresher courses for technicians, to be held in the Rhode Island Hospital, with the provision by it of substitute technicians to serve the affiliated hospitals during the absence of their technicians receiving the educational training.

6. Supervision of clinical laboratory work at the affiliated hospitals by the Institute's biochemist and bacteriologist, with unusual and complicated chemical and bacteriological procedures conducted at the laboratories of the Rhode Island Hospital.

Those primarily responsible for organizing the Institute believe that as it grows new opportunities for significant contributions to medical science and to the state's hospital service will evolve. A complete educational program is anticipated which will include the preparation of young men for National Board certification, a school for technologists, professional staff meetings, regional and state conferences, participation in specialized clinics, the teaching of interns and residents and, perhaps, of nurses, and an "ever-expanding acceptance of educational challenges within the Institute's scope of operation." It also has been suggested that laboratory service might be offered to individual physicians.

In addition to the pathologist-director, the staff is expected to include at least four assistant pathologists, with one specializing in neuropathology and one specializing in the pathology of blood forming organs and hematology, a bacteriologist and a biochemist, all assisted by technicians. Research is to be emphasized in all fields of work.

Although well in advance of most hospital practice, the organization of centralized services to serve all citizens of the state, through their local community hospitals, is in line with recommendations of national medical and health authorities who urge large, well-staffed and well-equipped hospitals to give leadership in state and regional integration of hospital services. A few of the nation's outstanding hospitals have successfully demonstrated that such coordination is practical and of inestimable value both to the hospital dispensing the service and to those receiving it. This is the first carefully planned organization of its type in Rhode Island.

The advantages of the Institute of Pathology which warrant particular attention include the amount of experience and resulting ability that is gained by participating pathologists through the

continued on page 458

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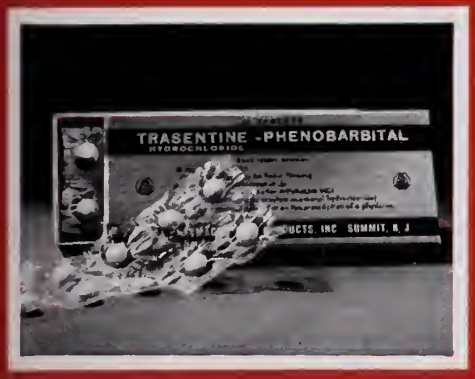
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*REFERENCES

Rambar, A. C., Hardy, L. M. and Fishbein, W. I.: J. Ped. 23:31-38 (July) 1943
Wolf, I. J.: J. Ped., 22:707-718 (June) 1943
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Wolf, I. J.: J. Med. Soc. New Jersey. 38:436 (Sept.) 1941

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THE PROVIDENCE LYING-IN HOSPITAL

THE Providence Lying-In Hospital has been approved by the A.M.A. for training of residents. There has always been a close affiliation with the Rhode Island Hospital which may be strengthened by a contemplated combined obstetrical-gynecological residency. This will make more intensive use of the educational advantages offered by the wealth of clinical experience and material at hand. At present, in addition to the two residents there are three internes. These internes for some time have been discharged medical officers renewing their skill before returning to practice. There are also two medical students from Tufts and two from Harvard Medical School.

During April and May, in association with the Pediatric Staff of the Rhode Island Hospital, and as part of a comprehensive course given by the Pratt Diagnostic Clinic of Tufts Medical College, the staff of the Lying-In has given a two week series of lectures, demonstrations, and informal round table discussions. This has been carried out under the direction of Dr. Bertram H. Buxton and Dr. John G. Walsh. The program as carried out for three groups of returning and newly released medical officers follows:

Monday	
Introductory Remarks	Dr. Buxton
Prenatal Care	Dr. Paul Appleton
Tuesday	
Pelvimetry and Pelvic Anatomy X-ray Conference. Pelvimetry and Pelviography	Dr. Alfred L. Potter and Dr. Russell Hunt
Obstetrical Nursing	Miss Helen Murdoch
Wednesday	
Classification of Toxemias	Dr. Walter Jones
Induction of Labor, etc.	Dr. Craig Houston
Thursday	
Clinical Conference.	Staff
Rh Factor	Dr. Wm. MacDonald Dr. George Tully
Rh typing, Laboratory Tests.	Miss M. deSilva
Hemorrhage in Obstetrics	Dr. B. H. Buxton

Few in Rhode Island, unless they were interested in the statistics of births, read the Hospital Number of the A.M.A. Journal for April 20, 1946 (Vol. 130, No. 16) carefully enough to place the Providence Lying-In Hospital among the other obstetrical hospitals of the country. For the year 1945 being reported this hospital with 5,272 deliveries was second in the United States. Only at the Margaret Hague in Jersey City with 6,726 were more babies delivered. We had again passed Israel Zion, of Brooklyn, and St. Joseph's Infirmary of Houston, Texas, where 4,917 and 4,836 were born.

The other hospitals in New England reporting more than 2,000 births were the Hartford Hospital, sixth in the United States with 4,663; the Boston Lying-In, forty-third with 2,498; the Boston City Hospital, fifty-ninth with 2,336; and the Bridgeport and St. Vincent's Hospitals in Bridgeport, and Wesson Maternity of Springfield.

To finish with statistics, of the 13,622 births in Rhode Island reported for the year 1945 the A.M.A. figures show the following hospital figures:

Providence Lying-In	5,272 births
St. Joseph's Hospital	1,198
Homeopathic	1,137
Newport	1,046
Woonsocket	1,040
Memorial Hospital, Pawtucket	1,027
Notre Dame, Central Falls	546
Westerly	422
South County Hospital	341
Miriam Hospital	309

Friday	
Abortion and Moles	Dr. John F. Murphy
Premature Separation of the Placenta	Dr. John G. Walsh
Monday	
Treatment of Toxemias	Dr. Walter S. Jones
Cesarean Section	Dr. A. L. Potter
Tuesday	
Anaesthesia in Obstetrics and Resuscitation of the Newborn	Dr. Meyer Saklad
Soft Tissue Placentography and X-ray of the Fetus	Dr. Russell Hunt
Placentography	Dr. Charles Potter
Analgesia and Anaesthesia in Obstetrics	Dr. Tully

continued on next page



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PROVIDENCE LYING-IN HOSPITAL

continued from preceding page

Wednesday

The heart in Pregnancy	Dr. Guy Wells
Diabetes in Pregnancy	Dr. Frank Matteo
Clinical Phenomena of Labor	Dr. Walsh
Forceps Delivery	Dr. Geo. Waterman

Thursday

Clinical Conference	Staff
Fetal Abnormalities	Dr. Appleton

Friday

Breech Delivery	Dr. Ralph DiLeone
Round Table Conference	Staff

One more group is at present planning to take this refresher course. Doctors throughout the state are invited to attend this course during the first two weeks in July. There is a round table conference held at the hospital at nine every Thursday morning to which the doctors of the state are invited. And of great interest is an X-ray conference held promptly at eleven on alternate Tuesday mornings by Dr. Russell Hunt. Any one is welcome who is interested.

For six months all patients, ward and private, have had routine prenatal blood typing and Rh factor determinations. The blood bank at the hospital is already paying dividends in lives saved and interest in improved morbidity figures by combating anemia.

With the return of Dr. Frederic Ripley now on terminal leave the last member of the obstetrical staff will have returned to civilan practice. The other members of the obstetrical staff who have previously been released from the army or navy are: Dr. George E. Bowles, Dr. Jarvis D. Case, Dr. George F. Conde, Dr. John A. Gormly, Dr. Richard E. Haverly, Dr. Walter S. Jones, and Dr. Joseph C. Kent.

The following have returned to the pediatric or consulting staffs: Dr. Reginald Allen, Dr. Robert Baldridge, Dr. William P. Davis, Dr. Banice Feinberg, Dr. F. Charles Hanson, Dr. Herman Lawson, and Dr. Ernest Thompson. Two men are still in active service, Dr. Eric Stone and Dr. Elihu Saklad.

DR. ALFRED L. POTTER, *Chief of Staff*
DR. HARMON P. JORDAN, *Superintendent*

RECENT STUDIES IN PREVENTION OF CERTAIN INFECTIOUS DISEASES

concluded from page 430

[33] Aycock, W. L., and Kramer, S. D., Immunity of poliomyelitis in normal individuals in urban and rural communities as indicated by the neutralization test. J. Prev. Med. 4, 189, 1930.

[34] Bahlke, A. M., and Perkins, J. E., Gamma globulin for preparalytic poliomyelitis, J. A. M. A. 129, 1146, 1945.

[35] Gregg, N. M., Tr. Ophth. Soc. Australia 3, 35, 1941.



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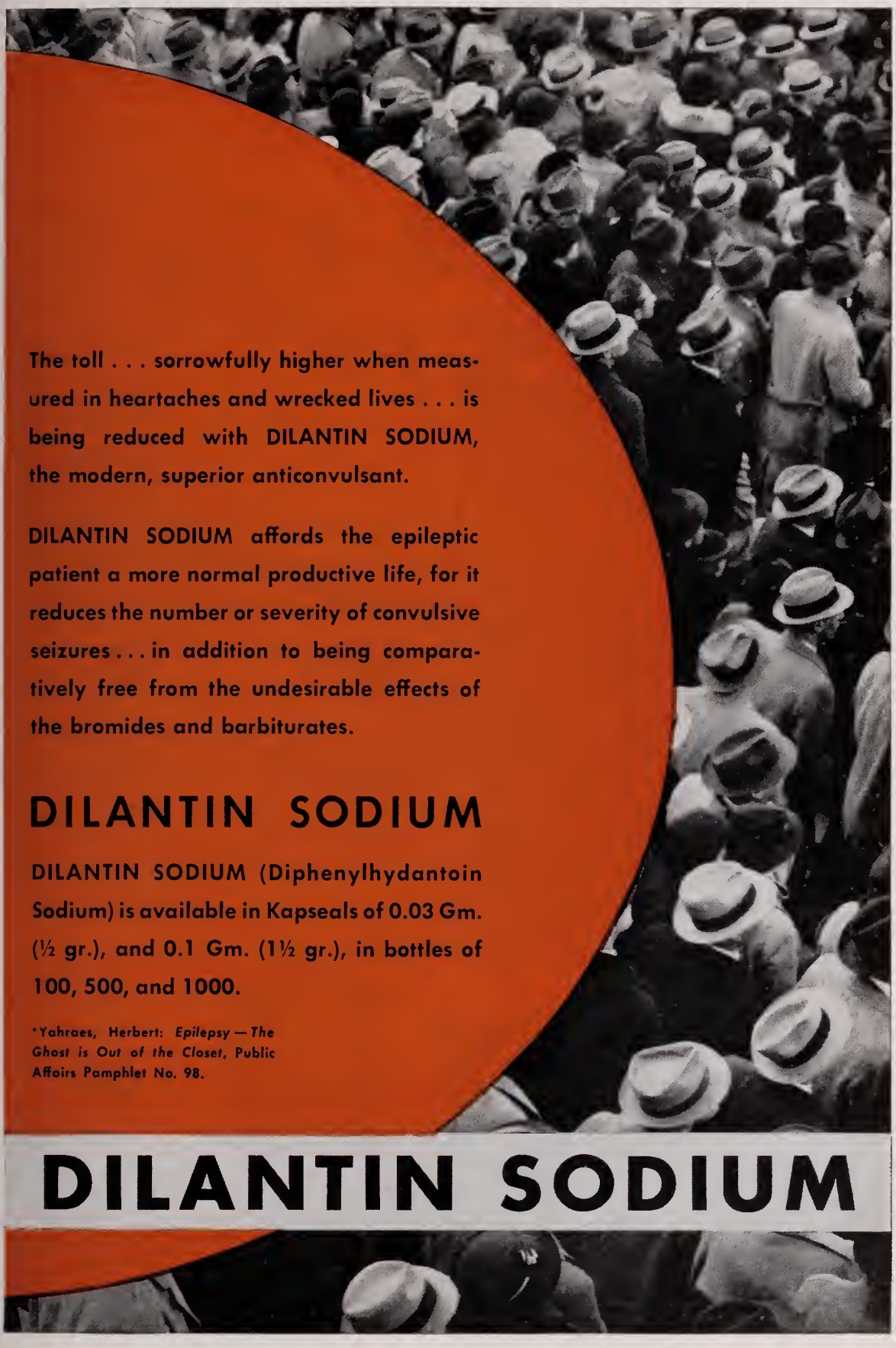
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*Yahraes, Herbert: *Epilepsy — The Ghost is Out of the Closet*, Public Affoirs Pamphlet No. 98.

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A DEVICE FOR HOLDING INTRANASAL TUBES

NELSON C. FONTNEAU, M.D.
Former Intern, Rhode Island Hospital. Now serving with the U. S. Army.

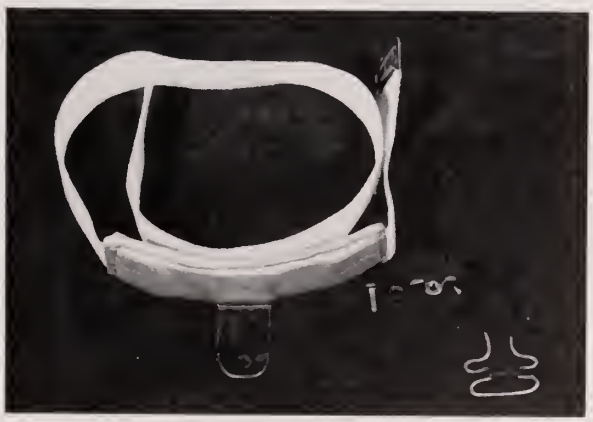
THE purpose of this paper is to present a device for holding in place such tubes as the Miller-Abbot, Levine, and others which are passed intranasally and allowed to remain in place over more or less extended periods of time. The author realizes that several devices for this purpose are in production on a commercial basis, however, the one described here is capable of being made in the orthopedic appliance shop of any moderate-sized general hospital.

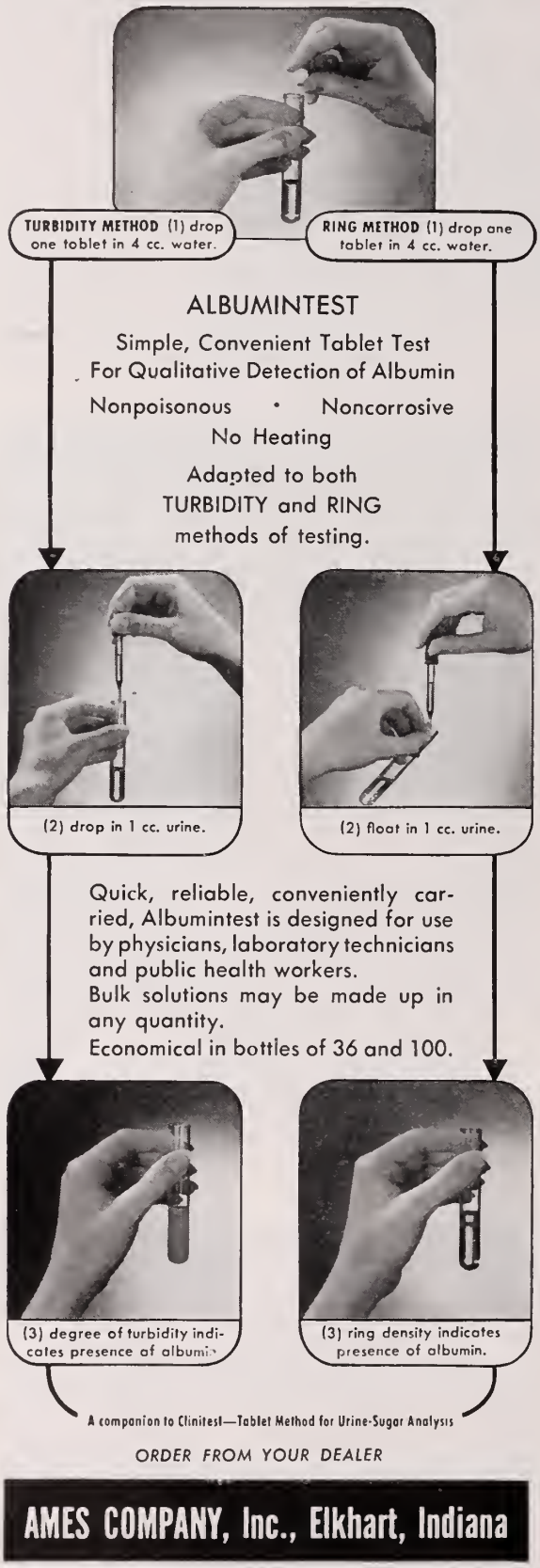
The apparatus is constructed in the form of a head-band with a 1″ by 4½″ strip of light metal, curved to conform to the forehead, padded with flannel, covered with soft leather, and incorporated in a 1″ webbing strap which goes around the head. The webbing strap is provided with a buckle to allow adjustment for head size. Projecting from the center of the metal portion of the headband at a right angle, is a 1″ by 1½″ bracket, which is fastened to the headband by rivets. The projecting corners of this bracket are rounded off and its end is drilled to accommodate a 3/16″ stovebolt. A piece of flat stock 1″ by 1½″ is then slotted along its center with a 3/16″ by 1⅛″ opening and to this is brazed a wire loop of 1/16″ material, shaped like a "U" with a small indentation on each limb of the "U". This latter assembly is fastened to the bracket of the headband by means of a short 3/16″ stovebolt, equipped with wingnut and lockwasher.

In use, the device is adjusted to a comfortable fit on the head, with the bracket over the forehead. The intranasal tube is then lead through the wire loop of the apparatus and is held in place there by a small elastic band passed on either side of the tube between the indentations on the limbs of the "U". The position of the tube may then be adjusted by sliding the bracket extension along the slot and/or by swinging the extension on one side or the other, the desired position being held by setting the wingnut on the bolt.

The use of this apparatus eliminates adhesive tape in holding intranasal tubes in place and hence not only prevents the tubes from falling out of place when tape is loosened by perspiration but also is more comfortable for the patient to wear. By adjusting properly the extension bracket, local pressure of the tube on the ala nasae may be relieved. The device described here has been in use for nearly a year at the Rhode Island Hospital where it has been adjudged an improvement over previous methods by staff members, nurses, and patients alike.







ANTI-POLLUTION DRIVES THROUGHOUT NATION SPURRED

Tightening of pollution controls in several states has put sewage and industrial waste disposal systems among foremost public works in cities from coast to coast, the American Municipal Association reports.

Indicative of nationwide interest in pollution control is a federal bill recently approved by the house rivers and harbors committee. The measure would provide $100,000,000 a year aid to construction of state and municipal sewage disposal plants.

State and interstate action is spurring municipal interest in pollution control. A seven-state pact to consolidate efforts aimed at cleaning up the Ohio river recognizes elimination of industrial wastes and sewage disposal as prime postwar projects. The Ohio division of conservation and natural resources has authority to obtain injunctions prohibiting pollution that destroys wild life and to sue for damages in event of contamination.

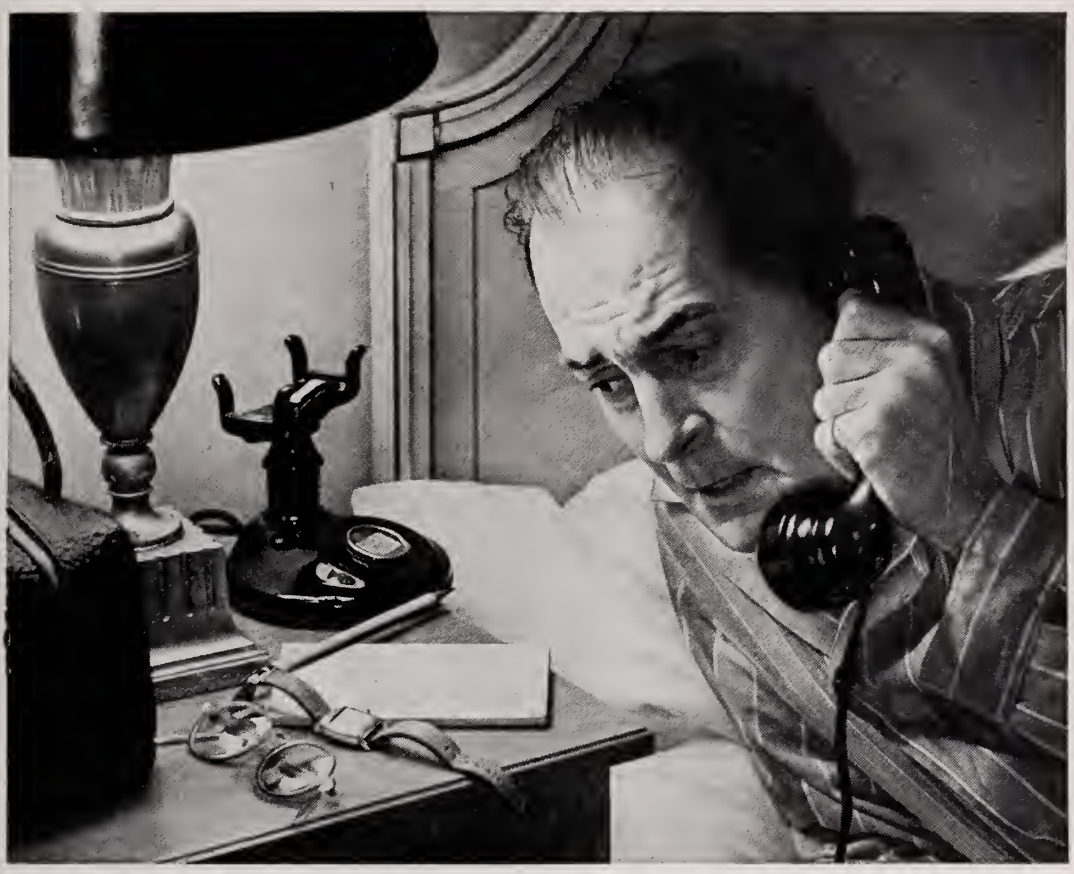
A recently enacted Virginia anti-pollution measure provides for creation of a state water control board to control disposal of sewage and industrial wastes. Washington's new state pollution control commission is directing activities of more than 60 cities that have authorized or are planning modern sewage disposal systems. Washington and Oregon are cooperating in a drive to reduce pollution in the Columbia River.

Pennsylvania's sanitary water board recently announced that 95 per cent of cities accused of polluting public waters have been notified to prepare plans for sewage treatment plants. More than 500 municipalities are involved. The Pennsylvania state health department plans to reduce pollution along the Schuylkill River by means of a campaign against municipal and industrial wastes. Controls are being imposed especially on collieries to reduce coal slack in the Schuylkill, which is one source of Philadelphia's water supply.

Pulp and paper manufacturers of North and South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, Texas and Arkansas plan to establish a research unit at Louisiana state university to help solve the industry's stream pollution problem. Similar research is underway in Alabama and Texas.

California cities are speeding completion of sewage disposal plans as a result of a recent state order to halt dumping raw sewage into coastal waters by the end of 1946. Six San Francisco bay cities including Oakland and Berkeley will vote in November on a $15,000,000 bond issue to finance a central sewage disposal system. San Diego officials indicate the city's $3,764,000 sewer program may be delayed because of lack of materials. Los Angeles is reviewing plans for a $3,000,000 submarine sewer, part of its $23,000,000 postwar sewage disposal program.

—News Bulletin of the Public Administration Clearing House, Chicago, May 23, 1946.



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DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, May 6, 1946. The meeting was called to order by President Paul C. Cook at 8:30 p. m.

The reading of the minutes of the previous meeting was omitted.

The Secretary reported the receipt of an invitation from the Rhode Island Section of the American Chemical Society inviting the members of the Providence Medical Association to attend a meeting on May 10 at which Dr. Max Lauffer is to be the speaker.

The Secretary reported for the Executive Committee as follows:

At its recent meeting the Executive Committee of the Association took the following action:

It approved of a survey of the membership in cooperation with the Occupation Adjustment Committee of the Community Workshops of Rhode Island on the question of the prevalence of epilepsy in this area.

It voted to send out a card questionnaire to all members in order to secure a list of those physicians willing to accept emergency calls in the day or in the night, and it voted that such a list be submitted to the physicians exchanges, the New England Telephone Company, and the police department for their reference.

It voted to recommend to the Association that it endorse the survey of child health services being undertaken by the American Academy of Pediatrics in cooperation with the Rhode Island Medical Society, and also to recommend the appropriation of the sum of $25 from the Association's funds towards the financial expense of the study.

It voted to accept the report of the sub-committee that studied present and proposed fees for home and office visits, and to send a copy of the report to each member of the Association.

It voted to consider any existing written fee schedule of the Association as obsolete.

It voted to accept the report of the committee on the study of a central telephone exchange, and to send a copy of the committee's report to each member of the Association.

It voted that the written records of the minutes of the meetings of the Association dated from 1848 be microfilmed for their better preservation.

It was moved that the report be accepted. The motion was seconded and passed.

The President called attention to the recommendation of the Executive Committee of the Association to endorse the Child Health Surveys and make an appropriation towards the financial support of the program. Dr. B. Earl Clarke moved that the Association adopt the recommendation made to endorse the Child Health Services Survey and also that it appropriate the sum of $25 from the Association's funds to assist in the study. The motion was seconded and unanimously adopted.

Dr. Peter Pineo Chase, Chairman of the Committee on Water Pollution, read a report from his Committee, a copy of which is attached and made a part of these minutes.

It was moved that the report of the Committee on Water Pollution be accepted. The motion was seconded and passed.

The Secretary reported that the Executive Committee recommended to active membership in the Association the following doctors:

Luther Lewis, M.D.	Jacob Stone, M.D.
Carroll Silver, M.D.	Joseph M. Zucker, M.D.
William J. O'Connell, M.D.	Nathan J. Kiven, M.D.

Dr. William M. Muncy moved the unanimous election of the physicians nominated for active membership by the Executive Committee. The motion was seconded and adopted.

President Paul C. Cook announced that Dr. Frank M. Adams had been appointed by him as a member of the Committee on Air Pollution.

The President reported that the Association had lost several of its members within the past few months by death, and he stated that tributes to these deceased members had been prepared by committees of the Association and that these tributes had become part of the permanent records. He read the following list:

Milton Korb, M.D.	Alanson D. Rose, M.D.
Michael B. Milan, M.D.	Howard Keefe, M.D.
Edward Campbell, M.D.	Raymond G. Bugbee, M.D.
Michael J. O'Neil	

Dr. Cook called for the membership to stand in silent tribute to the memory of these deceased members.

Dr. Cook introduced Dr. William H. Fischer of the Rhode Island Hospital. Dr. Fischer presented a case report entitled, "Quartan Malaria Following Transfusion." Three donors had been used, all of whom, on subsequent questioning, gave a history of malaria over forty years previously. Blood used had been stored in the blood bank at least five days.

continued on next page

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DISTRICT SOCIETY MEETING

concluded from preceding page

There was an interval of sixty-six days between the transfusion and the onset of clinical malaria. At the height of the first chill studied, the parasite density was sixty parasites per cubic mm., which is a distinctly low figure.

Dr. Cook introduced as the guest speaker of the evening Dr. Robert R. Linton. Dr. Linton spoke on "Thrombo-Embolic Disease—Prevention and Treatment."

He pointed out that thrombi originate most frequently in the posterior tibial and peroneal veins, and that they are adherent there. From this origin, they propagate upward, and then are not adherent, and at this higher site may break off and cause emboli. The highest incidence of cases follow surgical operation, particularly those for intra-abdominal malignancy. Approximately 82 per cent of cases occur in patients after the age of forty. From 1937 to 1945, 1,057 patients had 1,949 femoral veins ligated. Experience thus far has shown little or no evidence of subsequent edema or pain following this operation. The most important indication for this operation would appear to be evidence of pulmonary infarction. In 96 per cent of cases with pulmonary emboli, the emboli lodged in the lower lobes, so that this is the site to look for them in the x-rays. As regards technique, one important point is that the incision should parallel the large vessels to have adequate exposure for control of possible hemorrhage. Ligation of the inferior vena cava was discussed, and is a considerably more formidable procedure which should be reserved for special situations only. In general, early ambulation of surgical patients is a desirable procedure to prevent thrombo-embolic disease. Dr. Linton showed several interesting slides illustrating the points discussed, and a short movie in color well illustrating a typical operation for aspiration and ligation of the superficial femoral vein.

The meeting adjourned at 11:05 p. m. Collation was served. Attendance: 112.

Respectfully submitted,

FRANK B. CUTTS, M.D., *Secretary*



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WATER POLLUTION

Report of the Providence Medical Association's Committee on Water Pollution Accepted by the Association at Its Meeting on May 6, 1946.

A MEETING of the Committee on Water Pollution of the Providence Medical Association was held on April 23, 1946, and the problem was discussed from its various angles.

The pollution of Narragansett Bay is a huge problem and one which will require a great deal of money and time to correct. The pollution involves not only the small rivers which make up the head waters of Narragansett Bay but also the regions nearby, such as Newport, Wickford, Quonset Point, Mount Hope Bay and East Greenwich Bay. The correction of the Moshassuck, Seekonk and Woonasquatucket Rivers will help a great deal but will not solve the problem. That extensive pollution exists is a know fact. What is not known is that the bay as far down as Prudence Isle is probably contaminated. The line drawn at Conimicut Point infers that this large area between Conimicut and Prudence is free of contamination, and in this area there are a large number of shell fish growing. This means that probably contaminated shell fish are being allowed on the open market.

The Rhode Island State Board of Health should make a survey of the entire area as there has been no real examination of the bay in the last twenty years. The law, as it is now written, allows penalties against all the contaminators except for those in Newport and Jamestown. Why these two communities should have been exempted is hard for us to understand. They have just as much of a moral obligation to keep the bay clean as have the other offending communities. The contamination is extending farther down the bay with years as evidenced by the fact that tin 1912 21,000 acres were allowed for the cultivation of shell fish. This yielded a 2,000,000 crop and a rental revenue to the State of $135,000. The last figures available show the acreage has been reduced from 21,000 to 1,975 and the rental to the State has been reduced from $135,000 to $7,806.

In regard to the pollution by industry there is no question but that the major concerns are more than willing to do whatever is necessary to correct this. There is only need of a master plan and a feasible method of financing it.

In regard to the oil, and this is a sore spot to the bathers, the hunters, and the fisherman, much can be done. Your committee understands that it is customary for the oil industry to store gasoline in tanks which have a metal base, but that the tanks which are used for the storage of the heavy oils have no such bottom. Because of this the oil seeps through and makes its appearance in the bay by gravitation through the various layers of sand. We were astounded to learn that borings show that there is a heavy oil sediment through approximately 12 feet below the bottom of the upper bay. There is no question but that legislation can be and should be enacted which will correct this defect. No more storage tanks which are not absolutely leak proof should be allowed in Rhode Island and the larger tanks which are the source of this contamination should be made leak proof. Unless something along this line is done, this oily layer will increase and be a real source of trouble in the future.

The problem of oil leaking from tankers and from the various connections used in emptying these tankers is serious and in order to prevent this, strict adherence and enforcement of existing laws is necessary.

There are many organizations interested in the correction of this problem. Each organization has a committee working from the particular angle in which they are vitally interested. We feel that it might be well worth while for all these committees to get together, organize and then to apply pressure so that our bay may again become a recreational attraction for our State.

As a Medical Society, we are primarily interested in the medical angle and wish to emphasize the following:

That pollution of the shellfish is a health hazard. That it is going on and that nothing really is being done to keep these polluted shellfish away from the people. Many of the contaminated areas are being used by private individuals and by organizations and both of these are a source of a good deal of trouble.

Recently the bay patrol, which is altogether too inadequate for the purpose, arrested quohaugers in

continued on page 458



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WATER POLLUTION REPORT

concluded from page 456

the lower Mount Hope Bay and above Quonset. Both of these areas are contaminated.

As a Medical Society we are interested in seeing that all the natural recreational areas in our community are made available to the people of the State. Recreation is essential for good health, but Narragansett Bay with its pollution, instead of being a helping factor, can easily become the source of a mapor epidemic. It is our feeling that this improvement should be carried out without interference from the political parties.

We feel that a private corporation, something like the N. Y. Bridge Authority, can be formed and that the cost of the program can be spread over a period of years. The source of the income will be derived from those who contaminate the bay plus both State and Federal aids.

Respectfully submitted,

EDWARD S. CAMERON, M.D.
ANTHONY V. MIGLIACCIO, M.D.
PETER PINEO CHASE, M.D., *Chairman*

R. I. HOSPITAL INSTITUTE OF PATHOLOGY

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pooling of pathological material and the development of experts in special fields of pathology, as, for example, in neuropathology, hematology, gynecological pathology, the pathology of children and other specific aspects of an ever-widening science. At the same time that the individual has the opportunity to become an expert in that phase of pathology that particularly interests him, his association and study with a group will make him a better general pathologist, it is believed. Instead of the opinion of one man, combined study by the group will be directed on puzzling pathologic problems.

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HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting held on May 8, 1946

A REGULAR meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library, Wednesday, May 8, 1946. The following delegates and officers were in attendance:

Officers of Rhode Island Medical Society

Pitts, Herman C., *President-Elect*
Ladd, Joseph H., *Vice-President*
Buffum, William P., *Secretary*
Cutts, Morgan, *Assistant Secretary*
Ashworth, Charles J., *Treasurer*
Farrell, John E., *Executive Secretary*

Newport

Adelson, Samuel
Callahan, James C.

Pawtucket

Mara, Earl J.
Hanley, Henry
Henry, Robert

Providence

Baldridge, Robert
Belliotti, Joseph
Burgess, Alex M.
Buxton, Bertram H.
Calder, Harold G.
Chase, Peter Pineo
Crane, G. Edward
Cutts, Frank
Davis, William P.
Harrington, Peter F.
Jackvony, Albert
Lawson, Herman A.
Porter, Emery M.
Utter, Henry E.
Waterman, George

In the absence of the President, John F. Kenney, the Vice-President, Dr. Joseph H. Ladd, presided, calling the meeting to order at 8:10 p. m.

Dr. Ladd called for the report of the Committee on Postgraduate Education which was presented by Dr. Alex M. Burgess. A mimeographed copy of the entire report was submitted to each member of the House and Dr. Burgess read the report.

After reading Part I of his report, Dr. Burgess moved that this part of the report be received and placed on file. The motion was seconded and approved.

He then read Part II of the report, and he moved the adoption of it. The motion was seconded and passed. He then moved that publication of the list of specialists which is incomplete be confined for use in the office of the Society and not published or publicized until authority is given by the House of Delegates. The motion was seconded and passed.

Dr. Burgess read Part III of his report which was concerned with the care of veterans. He moved the adoption of Part III, to and including Subsection 3 of Section B, relating to the staffing of the veterans' hospital.

This part of the report was discussed and Dr. Charles J. Ashworth voiced objection to the adoption of the requirement that members of the hospital staff must be diplomates of their respective specialty boards, maintaining that it would be impossible for the Society to fulfill this requirement and authorize local physicians.

After a lengthy discussion, Dr. Burgess withdrew his first motion and moved that the House receive and place on file Part III of his report through Section B, Subsection 3, and without the final paragraph of Subsection 3 which makes the recommendation of the Committee. The motion was seconded. After a brief discussion the motion was passed.

Dr. Burgess moved that the House of Delegates, in receiving and placing on file the plan for medical care for veterans as discussed by General Hawley and as outlined in Part III of the report of the Committee on Postgraduate Education, does not thereby approve of that part of the plan as listed in Subsections 1, 2 and 3 of Section B, Part III of his report, requiring that the physicians must be diplomates of their respective specialty boards. The motion was seconded.

There was discussion of the motion, and Dr. George Waterman moved amendment to the motion to provide that the Society agree to fulfill the requirements of General Hawley's plan, as outlined by the Committee on Postgraduate Education, in so far as possible, and otherwise the Society will nominate candidates eligible for certification for the hospital staff membership. The amendment was seconded.

Dr. Ladd called for a vote of the amendment. The amendment was adopted.

After a brief discussion Dr. Ladd called for a vote on the original motion made by Dr. Burgess. The motion was passed unanimously.

Dr. Burgess completed the reading of Part III of his report and then moved that the final page of the report be received and placed on file. The motion was seconded.

Dr. Mara questioned the limitation of the supervision and arrangement of the training in the basic

continued on next page

Library Summer Hours

During August the Library will close daily at one o'clock, except on Saturdays when the closing hour will be noon.

The Library will not be open nights from June 15 through September 15.

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HOUSE OF DELEGATES

continued from preceding page

sciences to the Department of Medical Sciences of Brown University and suggested that it might be made general to include all the colleges in the State. He therefore moved that the science departments of the academic colleges and universities of Rhode Island be requested to arrange and supervise the training in the basic sciences as recommended in Subsection 4 of Section B of the report of the Committee on Postgraduate Education. The motion was seconded and passed.

Dr. Ladd called for a vote on Dr. Burgess's original motion as amended. The motion was passed.

Dr. Burgess completed the reading of his report and then moved that the report as a whole, as amended, be received and placed on file. The motion was seconded and passed.

Dr. Harold Calder moved that the President be authorized to appoint a special committee on veterans' affairs as recommended in the report of the Committee on Postgraduate Education. The motion was seconded and passed.

Dr. William P. Buffum stated that the annual report of the Secretary would be published in the MEDICAL JOURNAL, and therefore he would omit the reading of it before the House.

Dr. Charles J. Ashworth summarized the annual report of the Treasurer and submitted a complete financial report for the year, 1945, to the House of Delegates. Dr. Pitts moved the acceptance and filing of the annual report of the Treasurer. The motion was seconded and passed.

Dr. William P. Buffum reported that a special committee appointed by the President to consider the advisability of a Women's Auxiliary recommended that the House of Delegates of the Rhode Island Medical Society authorize the establishment of a Women's Auxiliary and that it appoint as the Advisory Committee the President-Elect of the Rhode Island Medical Society for the coming year as Chairman and the President of each of the six district medical societies as members. The Committee also recommends that the Auxiliary program be on both a state and district basis, and that the Advisory Committee be asked to develop the organization in the immediate future.

Dr. Buffum moved the adoption of the recommendation of the Committee on the Women's Auxiliary. The motion was seconded and passed.

Dr. Peter F. Harrington, chairman of the Committee on Social Welfare, submitted the report of his Committee which incorporated recommendations regarding fees for home and office visits, night and day, regarding classifications of specialists, regarding referral of welfare patients to opthalmologists, and regarding the East Providence, Warren, Bristol Medical Care Experiment.

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HOUSE OF DELEGATES

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Dr. Henry E. Utter moved the adoption of the entire report of the Committee on Social Welfare.

Dr. Herman C. Pitts made a verbal report on the status of the Rhode Island Cash Sickness Compensation Program, and he explained the new amendments to the law enacted by the General Assembly at its recent session. It was moved that the report as submitted by Dr. Pitts be approved as presented. The motion was seconded and passed.

Dr. William P. Buffum reported on the actions taken by the Council since the last meeting of the House as follows:

"Since the last regular meeting of the House of Delegates, the Council has taken the following actions:

1. "It empowered the President to appoint a medical-dental committee.
2. "It moved that the Trustees of the Society Building meet as a Committee to clarify the responsibilities of supervision and maintenance of the Society's activities and of the library building.
3. "It approved in principle the development of a statewide Health Council, and authorized the President to appoint a Committee of 5 to study the possibilities of such a Council.
4. "It approved of the appointment by the President of a committee to report to the House of Delegates on the advisability of a Women's Auxiliary.
5. "It moved that the Society acquire possession of the records of the Procurement and Assignment Service for physicians in Rhode Island.
6. "It approved of the transfer of the Charles F. Gormly Fund to the Society's general account, and authorized the Library Committee to utilize the money for the purchase of medical-legal texts to form a Dr. Charles F. Gormly collection.
7. "It approved of the expenditure by the Trustees up to $2,500 for needed improvements in the Library building.
8. "It recommended that the President communicate with the Governor of the State and offer the services of the Society in naming members of the Society to serve on committees created by legislative action.
9. "It approved of the continuance of the Council of the New England State Medical Societies, and appropriated $100.00 for the support of this Council's activities.

Dr. Buffum submitted the following recommendation from the Council to the House of Delegates:

> That the House of Delegates give its full support to the child health services study being conducted by the American Academy of Pediatrics in cooperation with the Child Health Committee of the Society, and that the Society appropriate the sum of $100.00 towards the financial support of the study.

Dr. Buffum moved the adoption of this recommendation. The motion was seconded and passed.

Dr. Buffum, secretary of the Society, submitted the recommendation of the Council of Dr. Arthur H. Ruggles as President-Elect of the Rhode Island Medical Society. Dr. Peter F. Harrington moved that the House elect Dr. Arthur H. Ruggles as President-Elect for 1946-1947 of the Rhode Island Medical Society. The motion was seconded and unanimously adopted.

Dr. Buffum moved the election of the entire list of nominees for officers and elected committees as presented by the Council. The motion was seconded and passed.

Dr. Ladd called for any resolutions by any district society or delegate.

Dr. Joseph L. Belliotti submitted the following resolution:

> WHEREAS the office of President of the Rhode Island Medical Society constitutes an honor that carries with it increasing duties and demands each year upon the time and energy of the encumbent, and
>
> WHEREAS the Society has been fortunate in having as its Presidents men who have devoted themselves unselfishly to the many tasks imposed by the office, and
>
> WHEREAS the Society has never adopted any method of expressing in some tangible way its esteem of its retiring President, be it
>
> RESOLVED that effective with this year of 1946 the Society present the retiring President each year with a gavel suitably inscribed, as a token of appreciation for his services as leader of the medical profession of this State during his term of office.

Dr. Adelson moved the adoption of this resolution. The motion was seconded and passed.

Dr. Peter F. Harrington submitted the following resolution:

> WHEREAS, there is an increasing tendency for government agencies to draft or establish minimum fee schedules for services provided the public through the administration of such agencies, and
>
> WHEREAS, the problem has been met in other communities by the adoption of a uniform fee schedule for governmental agencies,
>
> THEREFORE, BE IT RESOLVED, that the Rhode Island Medical Society undertake the adoption of a uniform fee schedule for wards and dependents of government by establishing a special committee of the House of Delegates to prepare and submit a proposed minimum uniform fee schedule at the scheduled meeting in September, 1946.

Dr. Mara moved the adoption of this resolution. The motion was seconded and passed.

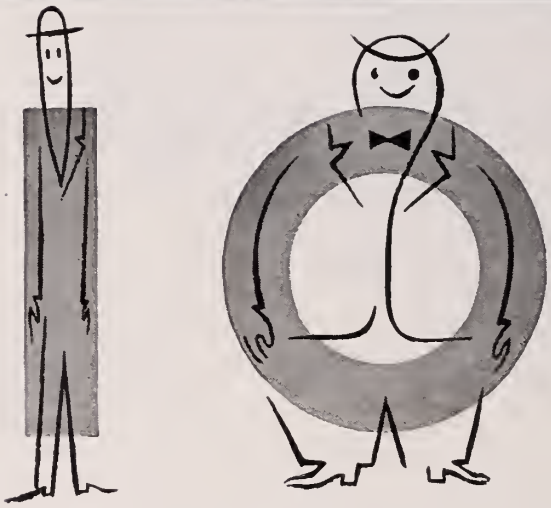
Dr. Earl J. Mara submitted the following resolution:

> WHEREAS, there is a constant expansion of health activities by various agencies of the State of Rhode Island, and
>
> WHEREAS, this expansion results in the duplication in many ways of effort, and also tends to increase otherwise the cost of medical care to the individual citizen, and
>
> WHEREAS, this situation is exemplified by the administration of a state Curative Center for the rehabilitation of injured beneficiaries of the Workmen's Compensation Act under the State Labor Department; by the administration of an adult rehabilitation program

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1. Handbook of Nutrition. Chicago A.M.A., 1943, p. 557.

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HOUSE OF DELEGATES

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under the State Department of Education; by the administration of a Cash Sickness Compensation Act, predicated on certification of illness, by the State Unemployment Compensation Board; by the administration of a medical care program for the public through the State Department of Social Welfare; and by public health activities in general by the State Department of Health, therefore,

BE IT RESOLVED that the Rhode Island Medical Society initiate a study whereby a Division of Medical Services, under the direction of the state director of health, may be established to administer a program of medical care in the state of Rhode Island for indigent and medically indigent persons, or either of such classes, and also to supervise and administer the medical phases, in cooperation with the respective state agency, of the Cash Sickness Compensation Act, the Vocational Rehabilitation Program, and the Curative Center.

Dr. Herman C. Pitts moved the adoption of this resolution. The motion was seconded and unanimously passed.

Dr. Mara moved that the President of the Society be empowered to appoint a Committee to study the proposal as recommended in the resolution relative to the initiation of a study regarding the establishment of a division of medical service under the direction of the State Department of Health. The motion was seconded and passed.

Dr. Herman C. Pitts submitted the following resolution with the recommendation that if adopted it be submitted to the House of Delegates of the American Medical Association at its annual meeting in July.

WHEREAS, the American Medical Association, through its House of Delegates has consistently favored insurance providing for compensation for the loss of earnings due to sickness, and

WHEREAS, compulsory cash sickness compensation programs are now in operation in Rhode Island and in California, and are being proposed in several of the other states, and

WHEREAS, such programs deeply concern the medical profession which must certify to the illnesses to permit beneficiaries to claim cash compensation, and

WHEREAS, experience in Rhode Island has shown that such certifications must be made by attending physicians if the health interests of the individual are to be fully protected, and

WHEREAS, the House of Delegates of the American Medical Association has expressed its opinion that the attending physician should be relieved of the duty of certification of illness and recovery, which function it believed should be performed by a qualified medical employee of the disbursing agency; be it

RESOLVED that the House of Delegates of the American Medical Association review and amend the action taken at its meeting in September, 1938, at Chicago, on the subject of insurance against the loss of wages during sickness; and be it further

RESOLVED that the American Medical Association through the proper Council or Bureau make a complete study of the existing and proposed compulsory temporary disability compensation programs, and that it report the findings of such a study, particularly as regards medical phases of the programs, to each of the constituent state medical societies before January, 1947.

Dr. Harold Calder moved the adoption of the resolution. The motion was seconded and passed.

Dr. Harrington addressed the House on the question of closer relationships between the Society and the State Department of Health. He cited the proposals for changes in the Health Laws, and he expressed the feeling that the State Director of Health is not always cognizant of the thinking of the House of Delegates of the Society on these matters. He suggested that the Director of Health be made a member of the House of Delegates in order that he might better understand the attitudes of the House on various health matters.

The discussion was concluded by a motion by Dr. Adelson that the House of Delegates invite the State Director of Health to attend all of its meetings. The motion was seconded and passed.

The Executive Secretary briefly discussed the situation as regards the proposed new Health Code which failed of enactment in the recent session of the Legislature, and he urged that the Society actively make known its opinions at public hearings before the Health Survey Laws Commission.

Dr. Pitts moved that the House of Delegates instruct its Committee on Public Laws to ask for a public hearing on the proposed new Health Code before the Survey Laws Commission in order to make known the attitude of the Rhode Island Medical Society on the legislation. The motion was seconded and passed.

Dr. Mara moved adjournment of the House at 10:35 p. m.

Respectfully submitted,

WILLIAM P. BUFFUM, M.D., *Secretary*

WELCOME HOME

The Rhode Island Medical Society reports the following Rhode Island physicians as honorably released from active duty, most of whom have resumed the private practice of medicine in this State as of June 1. Additional listings will be made each month and members are urged to report promptly upon their return to Rhode Island.

REGINALD ALLEN, M.D., 223 Thayer Street, Providence

J. MERRILL GIBSON, M.D., 185 Angell Street, Providence

WALTER HAYES, M.D., 1103 Cranston Street, Providence

LAURENCE A. MORI, M.D., 55 Pocasset Avenue, Providence

FREDERIC W. RIPLEY, JR., M.D., 167 Angell Street, Providence

MARK YESSIAN, M.D., 184 Elmwood Avenue, Providence

COMMITTEE ON POSTGRADUATE EDUCATION

Report to the House of Delegates of the Rhode Island Medical Society, May 8, 1946

PART I.

Activities of the Committee during the past year

1. *Aid to Returning Veterans*

Your Committee has cooperated with the office of the Executive Secretary in attempting to aid veterans to make such contacts with hospitals and other treating institutions as would help them in obtaining postgraduate training.

2. *Reports on "Medical Opinion in Rhode Island"*

The Committee has compiled three reports based on data gathered by Dr. Elihu S. Wing in connection with the preparation of his presidential address in 1945. The titles of these reports and dates of publication in the RHODE ISLAND MEDICAL JOURNAL are as follows:

Report 1—Diagnostic Centers, October 1945 (pg. 725)

Report 2—Group Practice, November 1945 (pg. 801)

Report 3—Local Certification of Specialists, December 1945 (pg. 927)

These reports have arouse some interest and have caused some comments.

3. *Listing of Rhode Island Specialists*

As directed by the House of Delegates the Committee has prepared a list of local specialists. This comprises Part II of this report.

4. *The Care of Veterans*

Following the publication of the plans of Major General Hawley for the medical care of veterans the committee proposed that General Hawley be invited to address the membership of the Society at the mid-winter meeting. Previous to the meeting the House of Delegates adopted the resolutions introduced by the Committee.

General Hawley spoke at the meeting and the resolutions were read to him and approved by him.

Following the meeting your Committee prepared a report on the care of veterans which constitutes Part III of this report.

PART II

Rhode Island Specialists

Foreword

A list has been compiled by the Committee on Postgraduate Education for the benefit of such agencies and individuals as may have a use for such a list. It consists of:

1. Those who have obtained certification by or membership in a nationally recognized board, college, or similar organization pertaining to a recognized specialty. This would include all those certified by the national specialty boards, fellows and associates in the American Colleges of Surgery and Internal Medicine and similar organizations of like national recognition and scope.

2. Those who have attained the rank of visiting physician or surgeon on the staff of any of the hospitals listed below. By this is meant the highest grade in any department or service next to chief of service. This would include pathologists, roentgenologists and anesthetists who had attained senior rank though not necessarily heads of their departments. Their certification would in each case be only in the specialty in which the doctor holds his hospital position and not in any other field, even one closely allied (e.g., a general surgeon would not also qualify as a gynecologist.)

It is emphasized that the Rhode Island Medical Society does not vouch for the competency of the physicians in various fields in which they are listed as specialists. The responsibility for listing them rests on the specialty boards that have certified them, the colleges and other organizations which have enrolled them, and the hospitals which have advanced them to the positions of senior visiting physician or surgeon. The present list is compiled from lists submitted by hospitals and specialty boards and beyond a doubt is incomplete, and the name of any physician who has been omitted and who has the qualifications specified will be added as soon as his name is called to the attention of the Committee. (Note: A number of recently returned veteran-physicians are in the process of completing their examinations for certification and their names shall be added to the list as soon as the Committee is notified of their acceptance.)

(In view of the fact that the House of Delegates voted that the publication of the list of specialists, which is incomplete, be confined for use in the office of the Society, and not be published or publicized

continued on page 471



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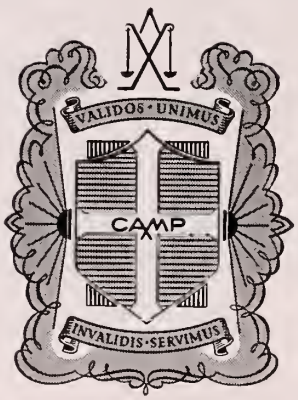
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COMMITTEE ON POSTGRADUATE EDUCATION

continued from page 468

until authority is given by the House of Delegates, it is deleted here from this presentation of the Committee's official report.—THE EDITORS)

PART III

The Care of Veterans

Foreword—General Hawley made it clear that the Veterans Administration is anxious to make any working arrangement with the Rhode Island Medical Society that is satisfactory to the members of the Society and that will accomplish his primary purpose which is to get for the veteran the best professional care available. He stated that he is quite willing to make the Society the responsible body to deal with the Veterans Administration and to contract with the Society, or with the surgical prepayment organization, as a body to handle the payment to physicians for services to veterans. He accepted the resolutions as passed by the House of Delegates with the modification regarding residents ("ward officers") that is noted below. On the basis of the statements made by General Hawley the following plans are suggested.

A. *Out Patient Service*

In the judgment of your Committee the Rhode Island Medical Society should negotiate a contract with the Veterans Administration to cover the out patient care of veterans and should set up a mechanism for handling payments to its members for this work. Your Committee believes that this can best be done by the office of the surgical prepayment plan when that organization is set up. As, however, the out patient care of veterans is already going on and the surgical prepayment plan is not yet established, your Committee believed that a contract may well be made which will involve the handling of the payments by the office of the Society until such time as the surgical prepayment plan is in operation. It is recognized, however, that the action requires careful study and planning and a recommendation for further investigation and action by a special committee will be presented later in this report.

B. *Veterans Hospital*

As expressed in the resolution adopted by the House of Delegates it is suggested that the Rhode Island Medical Society act in place of the "Dean's Committees" in the matter of nominating members of the active staff of the hospital as far as such staff members are to be drawn from the practicing physicians of the state.

The plan of the hospital staff, as explained by General Hawley, will include men in the following grades:

continued on page 473



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[1] Iost, V. J., and Kochergin, J. G.: Cod-Liver-Oil Treatment of Wounds, J.A.M.A. 106:586 (Feb. 15) 1936.

[2] Hardin, P. C.: Cod-Liver-Oil Therapy of Wounds and Burns, South.Surgeon 10:301 (May) 1941.

[3] Aldrich, R. H.: Cod-Liver-Oil Ointment in Surgery; 8-Year Study, Indust.Med. 11:153 (April) 1942.

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COMMITTEE ON POSTGRADUATE EDUCATION
continued from page 471

1. CHIEFS OF SERVICE. There will, according to the present plans, be five chiefs of service—Physician-in-chief, Surgeon-in-chief, Chief of the Department of Neuropsychiatry, Chief of the Department of Roentgenology and Chief of the Department of Pathology. These men will be full-time members of the Veterans Administration and all must be diplomates of their respective specialty boards. Local physicians who are qualified for these positions may be nominated with a good chance of appointment.

2. SENIOR CONSULTANTS. A number of older clinicians will be appointed from the local profession to act as consultants to the various services. These men will be called in from time to time and will be paid on a fee basis. They must be diplomates of their respective specialty boards. They will give advice as consultants or take part in the teaching program as need arises.

3. CONSULTANTS. From among the younger local clinicians a sufficient number of visiting physicians and surgeons will be appointed to carry on the work of the services as it is done in civilian hospitals. These men must be diplomates of their respective specialty boards. The title "Consultant" is the one authorized by the law but in practice their work will be that of attending or visiting men. They will serve half-time, approximately four hours daily, during their terms of service.

It is recommended by your committee that the Veterans Administration be requested to appoint a sufficient number of these consultants so that their term of duty will be three months in each year. This will allow men already on the staffs of civilian hospitals to accept these appointments and still carry on their work in the civilian hospitals whose staffs will thus not be unduly depleted.

4. WARD OFFICERS. These are actually residents who will be appointed from qualified recent graduates of medical schools. As they will not be appointed from the membership of the Rhode Island Medical Society it will not be the function of the Society to nominate them and they will, it is supposed, be obtained as are interns and residents in civilian hospitals.

The program of training these residents, however, will fall directly on the shoulders of the consultants and senior consultants drawn from the local profession. It is intended that these residencies shall be approved by their boards and their training requirements will therefore be quite definite as outlined by the American Medical Association ("Essentials of Approved Residencies and Fellowships", J. A. M. A. August, 1939, Vol. 113, pp. 794-799).

As regards training in the basic sciences, your committee recommends that the Department of Medical Sciences, Brown University, be requested to arrange and supervise such training. General Hawley has expressed approval of such an arrangement.

5. METHOD OF NOMINATION OF PHYSICIANS. In general, in the mattaer of nominating physicians for the positions of Senior Consultant and Consultant it is recommended that the Rhode Island Medical Society present to the Veterans Administration the names of all of its members considered fully qualified for appointment in these grades together with a detailed statement of the qualifications of each individual physician. The Veterans Administration would then make its selections on the basis of the data submitted.

6. DIRECTOR OF EDUCATION. It is reasonable to suppose that some individual would be in charge of the training program of residents as well as the educational activities of the staff in general. Whether such a function would be carried on by a full time officer of the Veterans Administration, a Senior Consultant, or a member of the Department of Medical Sciences at Brown would be, of course, decided by the Veterans Administration.

C. *Committee on Veterans Affairs*

Up to the present, by direction of President Kenney, the consideration of the relations of the Rhode Island Medical Society to the Veterans Administration has been in the hands of your Committee on Postgraduate Education, which suggested the visit of Major General Hawley to Providence and has obtained the information embodied in this report. This Committee has been concerned with educational problems of veterans and others but believes that for the general planning of the medical care of veterans in out patient and hospital services a Committee on Veterans Affairs should be appointed to supervise this whole matter with the exception of the subject of the education and training of physicians in the Veterans Hospital organization in which matter this committee should retain an interest and act in an advisory capacity.

Your Committee, therefore, recommends that the President appoint a special committee on veterans affairs to carry on further studies and formulate plans for the cooperation of the Rhode Island Medical Society with the Veterans Administration in the care of veterans. Your committee further recommends that to such a committee on Veterans affairs be assigned the task of the study and preparation of a contract for the out patient care of veterans by members of the Rhode Island Medical Society.

Respectfully submitted,

B. Earl Clarke, M.D. Harmon P. B. Jordon, M.D.
Elihu S. Wing, M.D. Alex M. Burgess, M.D.



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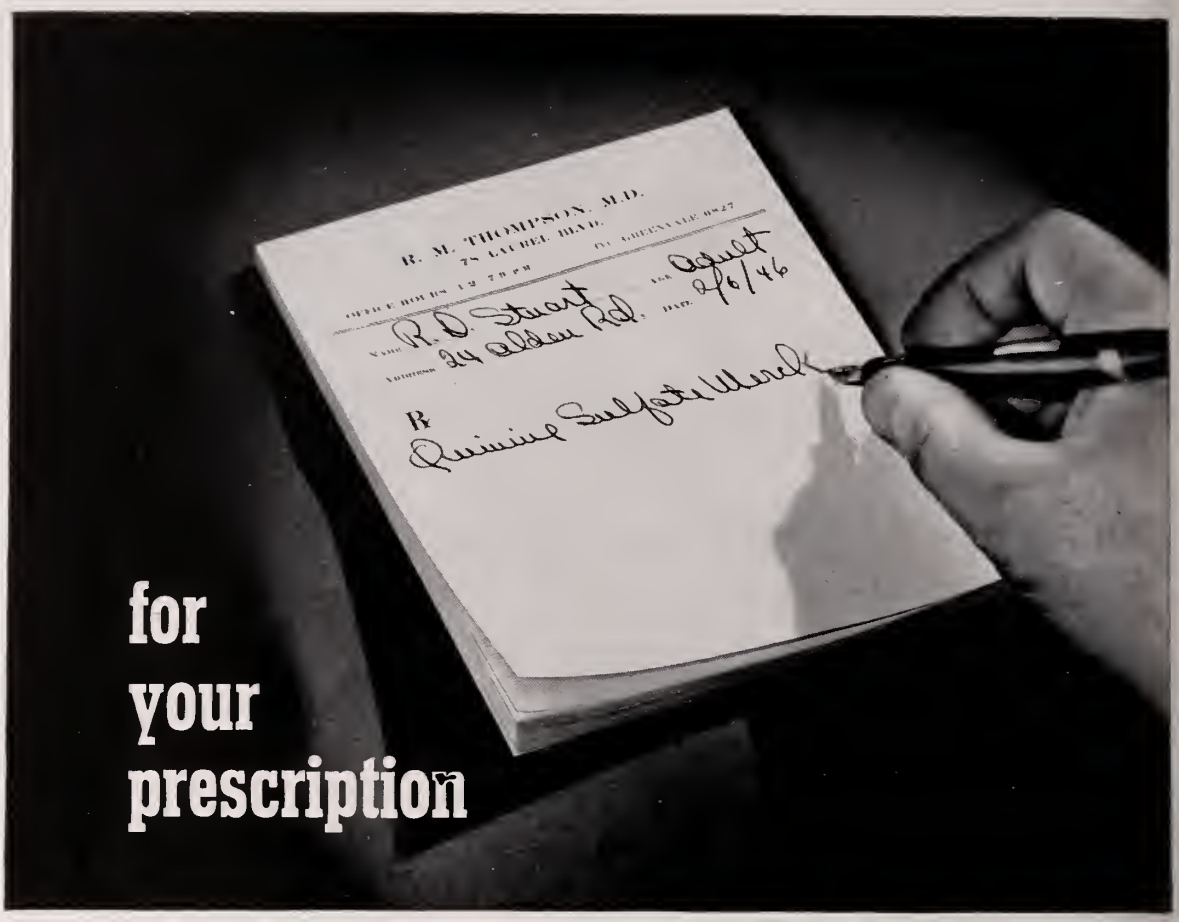


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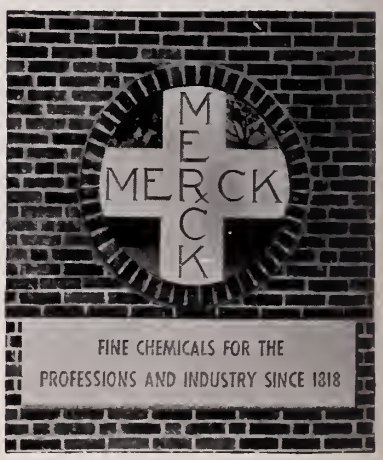


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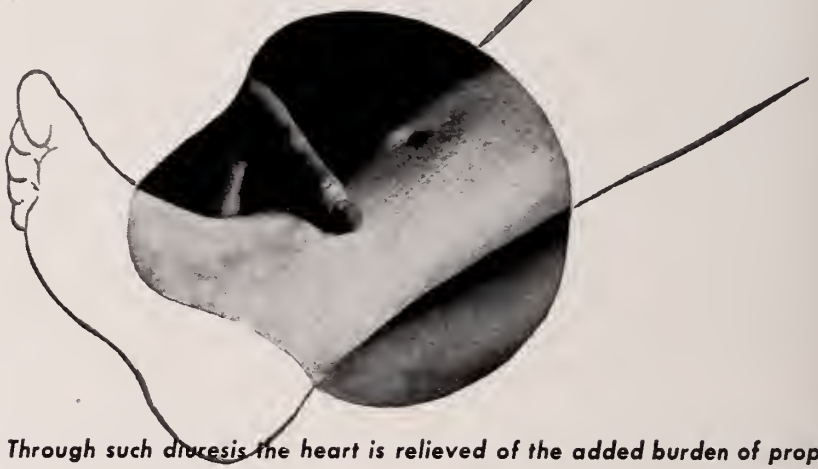
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Volume XXIX, No. 7

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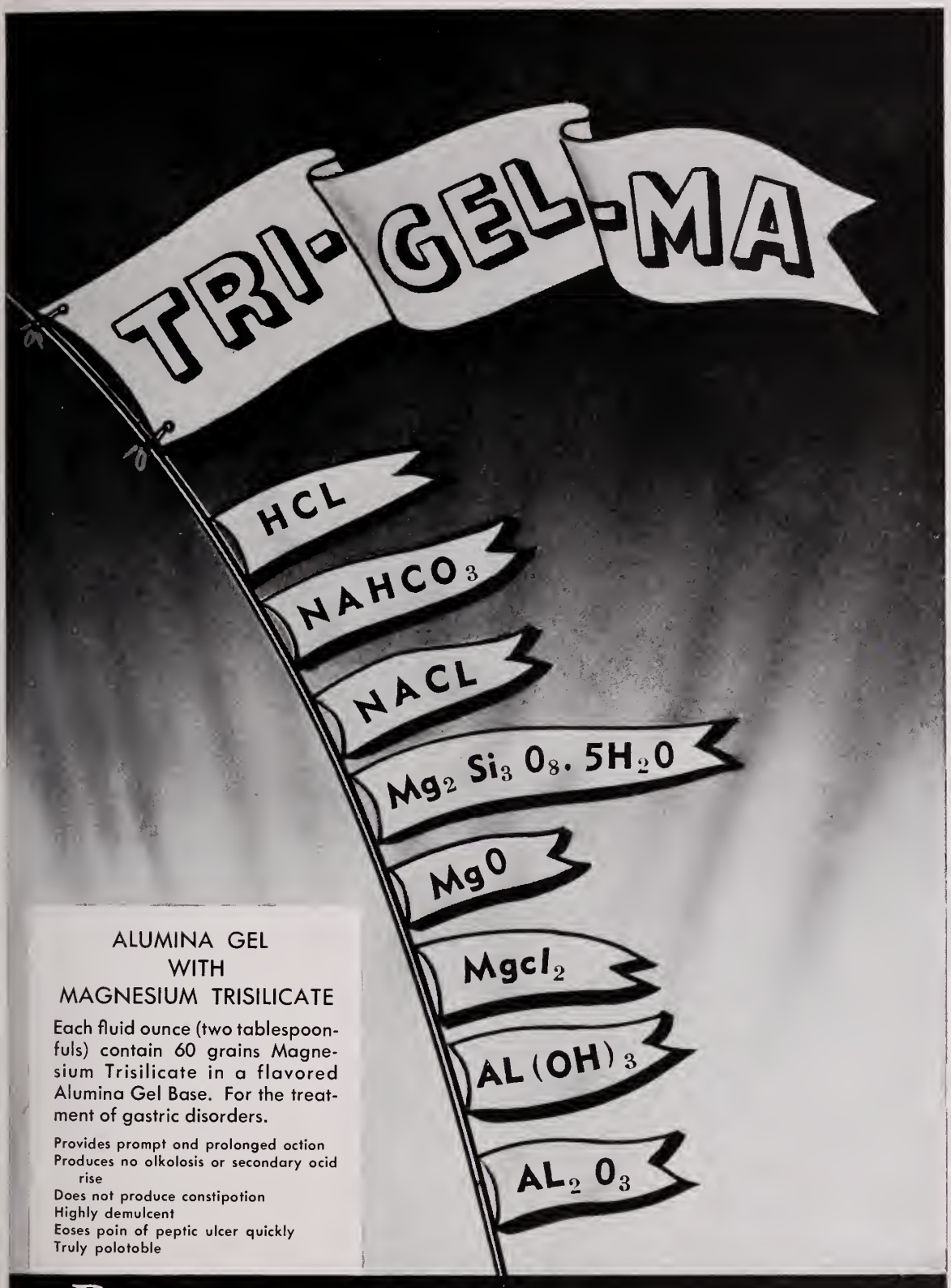
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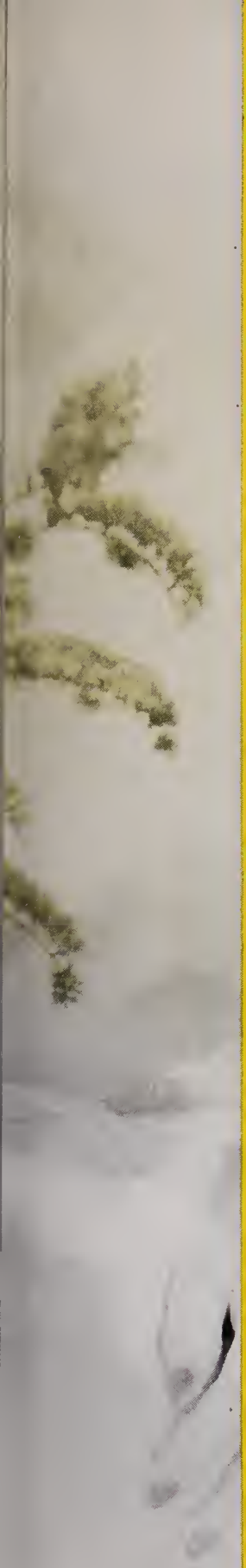


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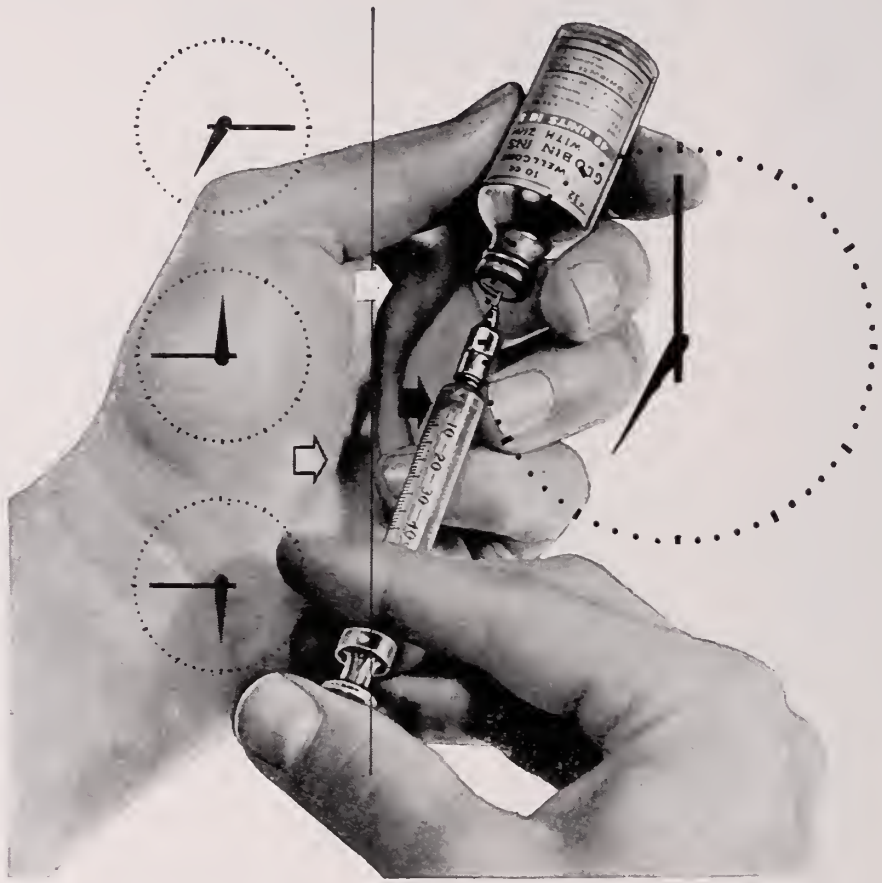
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THERE is little rest for the busy physician even after the responsibilities to his patients have been satisfactorily discharged. Medical journals subsist entirely on the writings of physicians. The articles, designed for the purpose of sharing knowledge with others, require arduous toil, and time not available during office hours. It is well to remember then, in reading medical journal papers, that some physician somewhere may have worked far into the night with the hope that his colleagues would benefit.

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXIX JULY, 1946 NO. 7

THE VIRUS TYPE OF INFECTIOUS HEPATITIS*

(Second Paper)

GEORGE BLUMER, M.D.

The Author. *George Blumer, M.D., of Pasadena, California. David P. Smith Clinical Professor of Medicine, Emeritus, Yale University School of Medicine.*

IN 1923 the writer published a summary[1] of the existing knowledge of the type of infectious jaundice which commonly occurs in the United States, and emphasized the following points: (1) its association with war, (2) its distinction from spirochetal jaundice, (3) that ordinary catarrhal jaundice was probably the sporadic form, and (4) its relation to acute yellow atrophy of the liver. Since then a large amount of new information regarding this type of infection has accumulated, especially during the war period, and another review seems desirable.[2]

Nomenclature

The nomenclature of many of the common diseases of the liver is thoroughly bad. It is desirable that the name of a disease should give clues to its etiology and pathology, and while the term *"Infectious"* Jaundice definitely denotes a parasitic etiology, it gives no information as to the type of infection or the pathology of the condition. In the future this disease should be called "The Virus Type of Infectious Hepatitis", even though the virus etiology is not yet proven to the hilt. Since Eppinger's studies during World War I, it is clear that the essential lesion in this type of infectious jaundice is a *hepatitis* and not a *duodenitis* with secondary obstruction of the common duct, as was commonly held since Virchow's time. It is advantageous to label the condition *hepatitis,* not only for the sake of precision, but also because this term suggests therapeutic approaches not inspired by the term jaundice. There is no serious objection to describing the epidemic type of the disease as acute epidemic hepatitis, as has been done by Danish physicians, if *virus type* is indicated, but some other terms, notably epidemic *catarrhal* jaundice, are misleading because they perpetuate a mistaken idea of the pathology, and should therefore be abandoned. The objection to such synonyms as "Jaundice of Camps" or "Jaundice of Campaigns" is that not only virus but also spirochetal hepatitis may be prevalent in armies.

Reportability

In my paper of 1923 I included a table listing the incidence of the disease by States, and showing that, at that time, no cases of infectious hepatitis had been reported from many parts of the country. This was doubtless due not to the absence of the infection from those localities, but to the fact that it was not reportable to the health authorities. This condition still holds, though to a lesser extent than in 1923. Recent correspondence with State and Territorial Health Officers shows, however, that the disease is even now reportable in but seventeen of the forty-nine States and Territories from which official information was obtained. In two States the disease is reportable only when epidemic; locking the stable door after the bird has flown, to use a mixed metaphor. The probable reason why the health authorities in so many States do not demand information regarding the incidence of the virus type of hepatitis is its low mortality; 1.8 per thousand among soldiers (Barker), and probably less in most outbreaks among civilians. However, as there are occasional outbreaks with much higher mortality and inasmuch as we now possess preventive measures, it is desirable that the disease should be reportable in all States, particularly as it is not infrequent in schools, orphan asylums, summer camps, hospitals, and other institutions. The fact that other, more serious forms of infectious hepatitis may occur in the same territory as the

continued on next page

* Presented before the Rhode Island Medical Society at its 135th Annual Meeting, at Providence, May 15, 1946.

[1] Infectious Jaundice in the United States. Jour. Amer. Med. Assn., 1923, *81,* 353.

[2] To keep the report within bounds the names of investigators are usually omitted from the text but will be found in the references at the end of the article.

virus type and must be differentiated from it, is also a reason for making the disease reportable. Furthermore, there is danger under existing circumstances that returning service men may import new and more virulent strains of the hepatitis virus. There is always a possibility that either existing local strains or imported ones may suddenly take on added virulence. One has only to recall the history of other virus diseases, poliomyelitis or encephalitis for example, to appreciate this potential danger.

Etiology

While the agent causing this type of infectious hepatitis has not been isolated, certain facts furnish presumptive evidence that it is a virus. It passes through filters impermeable to bacteria, it is resistant to a temperature of 56 degrees Centigrade for half an hour and also resists chlorination, the infection which it causes has a long incubation period and a blood picture similar to that of some diseases of known virus etiology. The experiments of Seide and Meding, who inoculated duodenal secretion from patients with hepatitis into chick embryos, showed that the etiological agent was capable of killing the embryos in 4 or 5 days. However, these observers were unable to isolate the agent or transmit it beyond the fourth generation, when it died out and was lost.

There is evidence which suggests that the causal agent of infectious hepatitis is not a single virus but that the disease may be caused by several closely-allied strains. The variation in the incubation period and clinical course of serum hepatitis as compared with the spontaneous form, and differences in the effect of different strains on test animals may be cited in support of this view. In Denmark, Andersen and Tulinius were able to transmit the disease from man to the hog, whereas in this country Eaton and his associates found the hog to be refractory to American strains from serum hepatitis.

Pathology

The recent studies of Lucké and others substantiate and elaborate Eppinger's findings based on material obtained during World War I. They indicate that the disease should be regarded as a general infection with preponderant liver lesions, rather than as a purely local hepatic disease. The process in the liver is a necrotizing inflammation of varying degrees of intensity. The necrosis of liver cells is usually present in every part of the organ, but there is marked variation in the extent of the process in different areas, and there is a definite tendency for the lesions, in their inception, to involve predominantly the centers of the lobules. In the liver framework, which is not destroyed, infiltration with lymphocytes, plasma cells, granulocytes and macrophages is present in varying degree. In most of the fatal cases the pathological lesions are those of acute necrosis of the liver (acute yellow atrophy) and, in such patients, most extensive destruction of liver cells, often involving whole lobules, is present. Occasionally death results from uremia due to bile nephrosis, particularly when severe dehydration has occurred. The main bile ducts are usually patent, rarely obstructed by inspissated mucus. The abdominal lymph nodes are commonly swollen and edematous, their sinusoids dilated and packed with polynuclear cells and macrophages. The spleen is frequently enlarged, and lesions in the gastrointestinal tract, particularly edema, and at times phlegmonous inflammation in the ileocecal region, have been noted. The last named lesion is doubtless due to terminal infection of the edematous bowel. The lesions in patients accidentally killed while suffering from infectious hepatitis as compared with those who died from the uncomplicated disease differ only in extent, so that it can truly be said that the pathological changes in the virus type of infectious hepatitis and those found in acute necrosis of the liver (acute yellow atrophy) differ only in degree.

Method of Spread

Studies made on human volunteers during the recent war have shown that the causal agent is present in the blood, the naso-pharyngeal secretions, and the feces of patients suffering from the spontaneous disease. Infection can be transmitted in human subjects by oral administration or nasal spraying of pooled feces and by intramuscular injection or oral administration of serum or whole blood. In some of the experiments serial passage in human beings was accomplished. Clinical experience suggests that the method of spread is not the same in all outbreaks. In many epidemics outspoken symptoms and signs of upper air-passage infection have been a prominent feature, in others these have been lacking. The distribution of patients in some epidemics, for example the one in Fond-Du-Lac County, Wisconsin, reported in my 1923 paper, rules out transmission by drinking water or food and suggests transmission by contact, probably through droplet infection, possibly through fomites. On the other hand there are outbreaks in which transmission by the alimentary tract is clearly indicated. Transmission through infected water, sometimes shown to be sewage-contaminated, has been reported by Fraser and others, and I have recently obtained reports of two milk-borne epidemics, one in Forsyth, Georgia (Drs. Murphy, Petrie and Work), and one in Wisconsin (Dr. H. M. Guilford). The observations of Andersen and Tulinius in Denmark indicate that in that country infection through the alimentary tract due to consumption of pork from jaundiced pigs is the common mode of transmis-

sion. Under war conditions especially, but in some instances in civilian outbreaks, association of the infection with unsanitary surroundings suggests the possibility of carriage of the virus by flies from human excreta to food. Furthermore, the question of transmission by suctorial insects has not been sufficiently explored to rule it out as a possible factor in some epidemics.

Serum Hepatitis

One aspect of the virus type of infectious hepatitis which has been highlighted by war experience is its transmission through the inoculation of prophylactic sera, and other preparations containing human blood. The observation is not a new one, for in the days of arm to arm vaccination against smallpox, in which human lymph was transferred, at least one outbreak from this procedure was reported. Reports of hepatitis following the use of convalescent measles serum were published long before the recent war. The wholesale inoculation of members of the American and British armed forces against yellow fever, with the resulting occurrence of many cases of infectious hepatitis, focused attention on this aspect of the disease. Since then it has been shown that not only the use of vaccines and convalescent sera, but also transfusion of whole blood, serum, or plasma and the use of extracted whole blood, may lead to attacks of the virus type of hepatitis. These occurrences make it clear that a virus capable of causing hepatitis may be present for some time in the blood of apparently normal convalescents. Whether this virus is identical with the strain causing spontaneous infectious hepatitis cannot be clearly proven until the two agents concerned can be isolated and compared. Immunological evidence is conflicting, as in some instances an attack of serum hepatitis protects against the spontaneous type, while in others it does not do so. There are clinical differences in the two groups of patients which will be discussed under symptomatology and diagnosis. It is to be noted that the injection of Gamma globulin made from pooled serum has not, so far, resulted in infectious hepatitis. Oliphant and his associates have brought forward evidence that passing blood or serum for the transfusion banks through artificial sunlight will destroy the virus.

Symptoms and Signs of the Spontaneous Type

For purposes of convenience the disease may be divided into 3 stages: (1) the preicteric or prodromal, (2) the icteric, and (3) the period of convalescence. The patient is usually sickest during the preicteric stage except in attacks which result fatally or in some patients with recrudescences during delayed convalescence.

After a *period of incubation* which averages about 28 days, but which varies between 20 and 40 days, the illness usually begins suddenly with the symptoms common to most infectious diseases: fever, sometimes with chills, headache, arthralgia, and generalized muscle aching, which later may be quite severe. The fever usually persists about three to four days, but may last a week longer. It is seldom very high and usually falls by lysis. In about one-third of the patients the onset is insidious rather than sudden.

In addition, most patients show symptoms referable to the upper air-passages, to the digestive tract, or a combination of the two. The usual respiratory symptoms are those of coryza, occasionally with sore throat; the common gastro-intestinal symptoms are anorexia, often profound, with nausea, vomiting and diarrhea. Some patients have respiratory symptoms at the onset and develop digestive disturbances with the icteric stage.

An interesting report from Dr. J. L. Carpenter, of New Hope, Alabama, contains facts indicating that the symptomatology may vary according to the point of entry of the virus. During the summer of 1944 Dr. Carpenter observed about 50 patients with infectious hepatitis, scattered throughout the general population of the neighborhood, all of whom had pronounced respiratory symptoms during the preicteric stage. In the spring of 1945 a second outbreak, limited to the pupils of one school, developed. In this endemic the symptoms during the prodromal stage were gastro-intestinal; notably persistent nausea and vomiting which was sometimes difficult to control. The school water supply was found to be contaminated. The evidence that the disease was water-borne was highly suggestive though not absolutely conclusive.

In the *icteric stage* digestive symptoms may be present or all active symptoms may subside, leaving the patient much more comfortable than during the prodromal period. The demonstration of yellowing of the conjunctiva and skin may be preceded by observation by the patient, of dark amber urine. The usual time for clinically-detectable jaundice to appear is four or five days after the onset of symptoms, but it may be apparent on the first day and occasionally does not appear for several weeks, sometimes during recrudescence only. The jaundice may range in degree from light lemon-yellow to deep orange, or the skin may even have a greenish or a cyanotic tinge. Icterus may persist for from two weeks up to seven months or longer, but usually reaches its maximum during the second or third week. Pruritus may occur with the jaundice, but is seldom so pronounced as in sporadic cases (catarrhal jaundice). In from 7 to 30 per cent of patients, the figure varying in different outbreaks, clinically detectable jaundice is absent.

The important *physical signs,* apart from the jaundice, are: (1) adenopathy, sometimes general-

continued on next page

ized, most common in the axillary, inguinal and cervical nodes, (2) an enlarged, tender liver, (3) conjunctival injection, and (4) enlargement of the spleen.

The enlarged lymph nodes are apt to vary in size and consistency in different stages of the disease. In the prodromal stage they may range from 0.5 to 3 centimeters in diameter and are usually soft and insensitive. As the disease progresses they tend to become firmer and smaller. They are always discrete.

The enlargement of the liver varies greatly in extent. The organ is palpable in about two-thirds of the patients, and the edge is commonly felt 4 or 5 centimeters below the costal margin in the right midclavicular line. Occasionally greater enlargement occurs, the liver reaching 9 or 10 centimeters below the costal margin or even to the iliac crest. About two-thirds of the patients have a tender liver and the tenderness may be brought out by direct palpation of the organ or by pounding the overlying ribs with the fist. In the writer's experience tenderness is often most pronounced in the region of the gall-bladder.

While the spleen is enlarged to the x-ray in the majority of patients, it is palpable in only nine or ten per cent. Evidence of enlargement may be missed because it is often transitory. There are indications that continuing palpable enlargement is more apt to be present in severely infected patients.

Rarer signs are macular, urticarial or petechial eruptions, and evidences of a hemorrhagic tendency in the form of mild epistaxis or occasionally slight hematemesis or melena. In the latter cases the hemorrhage must be differentiated from bleeding due to preexisting peptic ulcer which may start because the jaundice produces a tendency to hemorrhage.

Observations of the greatest importance concerning the *convalescent stage* of the disease have accumulated during the war period. From the older literature one gets the impression that while convalescence may be prolonged, recovery is almost always complete. I suspect that this is still true of the average epidemic in civil life. After all, members of the armed forces frequently contracted the disease while under conditions which were far removed from those of ordinary civilian existence. A combatant contracting hepatitis had often been subjected to severe and prolonged physical strain, his surroundings were frequently insanitary, and he had frequently been under unusual dietary conditions. Sometimes he had been without food for an abnormally long period of time, or he had been on artificial rations which, while technically adequate, were hardly comparable to a normal diet.

There is abundant evidence that among the armed forces, many patients who had suffered from virus hepatitis were returned from overseas because of failure to convalesce satisfactory. A minority of these patients were neurotics or psychoneurotics, the former usually exhibiting tremor and vasomotor disturbances, the latter gastrointestinal neuroses. The chief complaints of patients with delayed or unsatisfactory convalescence were: extreme weakness; overpowering fatigue; anorexia; imperfect digestion of fats, at times associated with nausea and vomiting; and pain or distress in the right upper quadrant often brought out by bending. About a fifth of them still showed enlarged, palpable livers, and many of them exhibited definite evidence of hepatic dysfunction when appropriate tests were carried out. The history of most of these patients showed that they had been subjected to stresses of certain kinds too soon after clinical recovery: physical exertion, even combat duty; indiscretions in diet, especially excess of fats; or abuse of alcohol. The important fact which observation of these patients brought out was that in virus hepatitis, as in rheumatic infection, clinical cure is not synchronous with healing. In a word, many patients who appear to have recovered from infectious hepatitis still have liver damage sufficiently severe to lead to temporary recrudescence, with a return of symptoms and signs, if the patient overexerts, indulges in certain foods or commits alcoholic excesses.

Symptomatology of Serum Hepatitis

The clinical picture of serum hepatitis differs from that of the spontaneous disease in minor details only. It is true that the period of incubation is much longer in the serum type, 75 to 135 days, with a mean of about 100 days, as contrasted with a mean of about 30 days in spontaneous hepatitis. The onset in serum hepatitis is much more likely to be insidious and, judging from some reports, jaundice tends to appear somewhat later and patients do not appear nearly so sick as those with the spontaneous disease. It has been noted too that dermatitis and anemia, not common in the naturally acquired disease, are quite frequent in serum hepatitis. It has also been observed that severe mental reactions are much more common in the serum type. On the other hand, fever is infrequent with serum hepatitis and lymphadenopathy is much less marked.

Laboratory Tests

Especially in the detection of hepatitis without jaundice, laboratory procedures are of great value. Examination of the urine shows the presence of bile in about three quarters of the patients, most pronouncedly so in the icteric stage but not infrequently both before and after this period. The methylene blue bilirubin test of Franke is an even more delicate index of bile excretion. With bile in

the urine there is commonly albuminuria with a high or normal specific gravity. In dehydrated patients evidences of bile nephrosis may appear.

The leucocyte count may range from a leucopenia under 3,000 to a leucocytosis of 38,000. The average count is within normal limits. During the preicteric stage leucopenia is common. Leucocytosis, when present, occurs later, but at this period also a relative lymphocytosis is usually present. A false-positive Wassermann and Kahn occurs in a few patients during the icteric stage. The heterophile agglutination test, and the coagulation and bleeding times are usually within normal limits. The sedimentation rate, commonly elevated after the first week, often remains so for weeks after the icteric index has returned to normal. The red cell resistance to the fragility test may be somewhat increased.

The stools are rarely completely acholic, though definite diminution in the bile content is common. The duodenal contents may show a few pus cells or rarely tyrosin or cholesterol crystals.

It is not the purpose of this paper to discuss the various tests of liver function in detail, but it is important that certain observations regarding them should be noted. It is significant that in many patients, both those tested during the active stages of the disease and those with delayed convalescence, simple laboratory tests furnish valuable information.

The *icteric index,* which in most patients is continuously above normal for nearly 6 weeks, may still be high in patients with retarded convalescence months after the acute attack. It usually rises rapidly during the late preicteric and the icteric stage and falls rather rapidly as convalescence approaches. In ordinary cases it ranges from 15 to 120 units, but much higher readings are occasionally encountered.

A biphasic *Van den Bergh reaction* is usually present throughout the disease, and in the first and second weeks a direct reaction is present in about one-third of the patients. The biphasic reaction may persist in patients with retarded convalescence.

The points to realize about the more complex tests of liver function such as the hippuric acid test, the cephalin-cholesterol flocculation test, the galactose tolerance test, and the sulfbromphthalein test, are: first, that when positive they give most pronounced results during the acute stage, and second, that none of them is positive in 100 per cent of patients with infectious hepatitis. If the simpler tests leave doubt as to the presence of liver damage one must not depend for further evidence on a single test of liver function but must employ several. As Rappaport puts it, it is important to employ "a medley of diagnostic methods."

In addition to laboratory methods the graduated exercise-tolerance test of Barker, Capps, and Allen may be employed in patients in whom the diagnosis is doubtful, or during convalescence when it is desirable to find out whether liver damage persists. The test is based on the fact that the liver enlarges and becomes tender after exercise if morbid changes in the organ still persist. The fact that the exercise is graduated allows discretion in carrying the test through. In case of unfavorable reaction to the early stages, the later, more strenuous ones, may be omitted.

Diagnosis

In the preicteric stage the diagnosis of virus hepatitis may be impossible. In the presence of an epidemic the disease may be strongly suspected, but in sporadic cases an early diagnosis of upper-air passage infection, acute enteritis, influenza, malaria, or atypical pneumonia is likely to be made. The appearance of an enlarged, tender liver, even though clinically recognizable jaundice is absent, should put the clinician on guard, especially if associated with adenopathy. The discovery of such a liver, particularly if associated with right costo-

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Dr. George Blumer, of Pasadena, California, David P. Smith Clinical Professor of Medicine, Emeritus of Yale University, addresses the 135th Annual Meeting of the Rhode Island Medical Society.

vertebral tenderness, calls for careful examination of the urine for bile and bilirubin, an estimation of the icteric index, a leucocyte and differential count and one or more functional liver tests. The appearance of jaundice is, naturally, an even more significant clue.

Leaving aside yellow fever, which causes a specific form of infectious hepatitis, the virus type must be distinguished from the spirochetal type (Weil's Disease) and the incidental type, which latter may accompany a variety of infectious diseases. It must also be remembered that, inasmuch as virus hepatitis is sometimes afebrile, it must be differentiated from the toxic hepatitis of poisoning by arsenicals, phosphorus, chloroform, carbon tetrachloride, TNT, and a number of less common poisons.*

The differentiation of virus from spirochetal hepatitis is usually not difficult. In spirochetal hepatitis there is frequently a history of contact with rats or with substances likely to be contaminated with rat urine. In the United States most cases of Weil's Disease occur singly in males, and familial, institutional, and community outbreaks are decidedly unusual. The striking hemorrhagic phenomena of spirochetal hepatitis are lacking in the virus form, as are severe renal lesions, except rarely in dehydrated patients. The polynuclear leucocytosis of Weil's Disease is seldom seen in the virus form, in which also the isolation of spirochetes and the agglutination and mouse protection tests are absent.

In incidental hepatitis, occurring as part of the picture in a generalized sepsis or an acute specific infection, diagnosis may occasionally be difficult. Almost any of the common infections may occassionally be complicated by hepatitis. At times specific infections, bacillary dysentery for example, may precede or accompany virus hepatitis. Incidental cases of hepatitis are due to the organism causing the general infection: the staphylococcus, streptococcus or gonococcus, for example. They may produce enlargement of the liver and jaundice but lead to little or no modification of the general picture, and are usually recognizable as an incident in the course of such infection rather than a specific complicating disease. In some chronic diseases: heart disease, cirrhosis, diabetes, a complicating hepatitis may develop and this may be a virus hepatitis or may be one secondary to a terminal infection with bacteria.

There is one other virus disease which may, for a time, be difficult to distinguish from virus hepatitis, namely Infectious Mononucleosis. John Paul states that jaundice occurs in ten per cent of patients with this disease, and suggests that it may be caused by a virus which is a first cousin of that causing infectious hepatitis. Study of the liver in the occasional fatal cases of infectious mononucleosis shows a diffuse, focal hepatitis, but the infiltrating cells differ from those commonly seen in virus hepatitis, being mainly lymphocytes, swollen Kupfer cells, mononuclears and occasional polynuclears and eosins. Even so, the clinical differentiation of the two diseases may be difficult, though a positive Paul-Bunnell test and the presence in the blood smears of characteristic leukocytes in cases of mononucleosis may decide the issue.

Prognosis

There is clinical evidence in many reports on infectious hepatitis that certain conditions, present before the infection was contracted, tend to exert unfavorable influence on its progress. In some of the earlier epidemics it is stated that the fatalities were mostly in feeble infants or the aged and infirm. In other outbreaks, as was true in the influenza pandemic of 1918-19, pregnancy rendered the prognosis more grave. In a recent fatal case, seen with Dr. R. A. Cunningham, the patient had been on a reducing diet for some months with low carbohydrate intake. Inasmuch as a diet high in carbohydrates is essential to protection of the liver cells, it is clear that not only patients on reducing diets but also diabetics under treatment, present a special problem if they contract infectious hepatitis. The importance of adequate liver cell protection in the prognosis can be readily appreciated when it is realized that the great majority of fatalities are due to acute or subacute necrosis of the liver (acute yellow atrophy). As previously noted dehydration with urinary concentration may cause a bile nephrosis with death from uremia, but such cases are not common. Rarely patients die of gastric or duodenal hemorrhage, from pre-existing ulcer. In outbreaks among civilians it is not uncommon to have an entire lack of fatalities, the average mortality being probably not above 1.5 per thousand.

Prevention

The question of preventive measures arises particularly in institutional or other group outbreaks, and, as has been noted, the disease may occur in schools, summer camps, orphan asylums, and institutions for the feeble-minded, as well as among military units. In school epidemics the younger school teachers may be infected, and doctors are by no means exempt. I have seen two endemics among nurses in general hospitals and others are reported in the literature.

There is no specific preventive at the present time. However, it has been shown by Stokes and Neefe that the parenteral injection of gamma globulin, so successful in the prevention and attenuation of measles, may also protect against infection

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* See the Present Status of Non-Obstructive Jaundice Due to Infectious and Chemical Agents. Reuben Ottenberg and Rose Spiegel. Medicine, 1943, *22*, 28.

PROGRESS IN CEREBRAL PALSY

ERIC DENHOFF, M.D.

The Author. *Eric Denhoff, M.D., of Providence. Assistant Physician and Director of Clinical Laboratory, Bradley Home, East Providence; Assistant physician, Outpatient Department, Department of Pediatrics, Rhode Island Hospital.*

CEREBRAL PALSY in children is not one disease, but a variety of syndromes in which neuromotor dysfunctions of various types are outstanding symptoms. Common usage has implied that the terms Congenital Spastic Paraplegia, Infantile Cerebral Paralysis, Birth Injury, and Cerebral Spastic Paralysis, etc. are synonymous. Actually these are specific entities, but are usually grouped together because of common etiologic agents. These may be hemorrhagic diseases, cerebral hemorrhage, embryologic defects, infections, anoxia, or other factors that produce pathologic change in the central nervous system.

In a clinical sense, the term Cerebral Palsy is used to signify a paralytic condition present since birth in which spasticity, athetosis, ataxia, or dystonia, are predominant findings. The inability of children suffering from these disorders to acquire motor skills in a normal manner is a reflection of cerebral damage which may vary from gross destruction to scattered cytologic degeneration in the cortex, basilar region, or cerebellum. The syndromes, comprised of motor, behavior, and mental components, depend upon the extent and site of the lesions. Damage to the motor portion of the cerebral cortex produces spasticity. As a result, the "spastic" child suffers from tightened muscles with a diminished range of motion. When the basal nucleii are injured, constant involuntary purposeless motions become manifest. This, for want of a more descriptive term, is called athetosis. Damage to the cerebellum produces ataxia, while diffuse subcortical pathology may produce tremors or rigidity.

In any process where mechanical or biochemical disturbances of neuromuscular apparatus exists, alterations of intelligence and personality may be encountered. On the basis of pathology, mental deficiency is more likely to occur when there is cortical damage.

The physician sees children with cerebral palsy in every crippled children's clinic. If their gait is clumsy or if they walk stiffly with conscious effort, their arms held tightly, they are "spastics". If they are athetotic they may sit on the floor of the clinic, head bobbing and saliva dripping. Every time they try to reach for something, they become hopelessly involved and entangled in a mesh of purposeless movements. They are the most unattractive of the crippled children. Their speech may be thick and poorly understandable and they *appear* mentally inferior to the other crippled children in the clinic.

Phelps, who has done a great deal to clarify concepts of patients with cerebral palsy discusses current opinions concisely in a recent text.[1] He distinguishes several types of cerebral palsy, and emphasizes the necessity for different treatment in each type. The "spastic" child requires relaxation of muscle so that range and motion will be enhanced; the "athetoid" needs general relaxation to help control his constant driving motions; the "ataxic" child requires training in balance and coordination. The treatment consists not only of physiotherapy, but also re-education in the form of speech training, vocational guidance, schooling, psychiatric treatment, and parent education. Phelps states that surgery is a necessary adjunct to correct spastic deformities, and drugs may be useful to decrease tremors and rigidity.

It should be emphasized that these children are suffering from a condition which is chiefly mechanical and has little bearing on general health. Little improvement can be expected without training, which in most instances must be maintained over a period of years. Mental deficiency, convulsive disorders, and regressive forms of post-encephalitic states adversely influence the prognosis. Yet, of the approximately six living children per 100,000 population that are born each year with cerebral palsy, perhaps four may be of normal or superior intelligence, three of whom are usually capable of physical improvement.

Progress in Diagnosis

The physician should diagnose cerebral palsy in his patient early, because it is in the early childhood years that treatment and training are most efficacious. Unfortunately early diagnosis is not common because the diagnostic methods and laboratory procedures available in the average community are of little help. Diagnosis in infants and young children requires special equipment, and the capable

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diagnostician must have an intimate knowledge of developmental behavior mechanisms. Competent neurologists, orthopedic surgeons, and psychologists are essential consultants in the diagnostic set-up. Research in developmental behavior, in psychometrics, in muscle and nerve physiology, and electronics, has paved the way for practical clinical approaches to a hitherto untenable medical condition. However, these advances are not yet available to most physicians.

Developmental Examination: Gesell and Amatruda[2] have eliminated some of the haziness surrounding deviations from normal development in infants. Through the utilization of systematic studies of every possible behavior mechanism in the normal and abnormal child, and with the aid of ingenious movie recording devices, they have outlined practical methods to help interpret minimal deviations presented by the infant with neurologic injury. Their work provides a solid background for the diagnosis of cerebral palsy. They have classified four fields of behavior: (1) Motor, (2) Adaptive, (3) Language, (4) Personal-Social. A study of motor behavior concerns muscle control and coordination, as well as posture, balancing, sitting, standing, grasping, etc. Adaptive behavior involves the finer sensori-motor coordinations, such as coordination of the eyes and hands in reading or in manipulation. Likewise, deviations in language behavior (not only speech but facial expressions and gestures as well), and study of personal-social behavior (adaptability to social surroundings including bowel and bladder habits, feeding ability, etc.) are important clues in the early diagnosis of neurological disorders. Gesell and Amatruda classify behavior mechanisms in chart form for practical use. They also describe developmental tests. Gesell believes cinema recordings a most valuable aid in the analysis of defective behavior patterns associated with cerebral palsy, and uses the movie chiefly for that purpose.[3] An examination of this sort enhances the early diagnosis of cerebral palsy.

Psychometric Tests: The evaluation of mental status—perhaps the most important practical issue in palsied children—has been more significant since the development of the Vineland Social Maturity Scale.[4] This scale reflects *actual attainment* rather than potential capacity. The evaluation of the developmental status of the patient is obtained from questions asked parents or friends. "Social" quotients obtained from a test of this nature are of great significance in crippled children because they evaluate mentality in the light of physical handicap.

Electromyography: That characteristic action currents from damaged muscle can be demonstrated graphically has long been known. However, a practical diagnostic method has only lately been available in spastic or dystonic conditions because of technical difficulties. Recently skillful workers have shown it possible to make oscillographic records of different muscles simultaneously without interference from related antagonists.[5] This method involves the use of apparatus similar to that used for electroencephalography. Topical electrodes, four action current amplifiers and a multiple recording oscillograph are utilized. The fact that even in spastic muscle there is a position of complete relaxation as evidenced by the electromyogram[6] is encouraging to those interested in the use of drugs to enhance relaxation of muscle. If the myogram is interpreted along with other tests for muscle strength, an accurate evaluation of the response to muscle training is afforded.

Electroencephalography: The electroencephalograph is sometimes useful in localizing cortical pathology associated with cerebral palsy. This is especially true in the cases of recent trauma, or where progressive and expanding lesions are involved. Areas of cortical atrophy can often be detected. Frequently the electroencephalogram reveals the presence of disordered brain physiology in the absence of observable neurological signs. The technique is now widely used in children in the diagnosis of convulsive disorders and the localization of cortical lesions.[7]

Pneumoencephalography: The pneumoencephalogram has lost its wide popularity in diagnosis since electroencephalography has become available for general use. An X-ray following air injection into the ventricles is still an excellent method for localizing cerebral tumors or areas of cortical atrophy. Since the air encephalogram is not a simple procedure in children, it is usually reserved for corroborative evidence of suspicious electroencephalographic findings. Incidentally, Amatruda[8] believes there is little correlation between the pneumoencephalographic findings of cortical damage and developmental progress. In a group of children in whom X-ray evidence showed indisputably that there was cerebral injury or degenerative disease, the development proceeded normally. This is reassuring to those interested in the ultimate outcome of a patient with known cerebral damage who is progressing well.

Progress in Re-Education

The ultimate aim in any cerebral palsy program is for the patient to achieve independence. Once the basic diagnosis has been established, not only must the immediate plan for physical training be instituted, but also educational, vocational, and psychological guidance must be integrated to form the training program. Several hundred articles and books, varying from highly technical medical data to simple advice to parents and lay workers on

the general needs of the cerebral palsied have been published. These are listed in a cerebral palsy bibliography.[9] The variety of articles emphasizes the vast scope and detail entailed in re-education.

Physiotherapy: The basis of re-education is physiotherapy. Muscle training through relaxation and exercise results in the establishment of control. The physiotherapist must be so well acquainted with the intrinsic mechanisms encountered in the various syndromes of cerebral palsy, that she is able to modify standard procedures to meet individual needs. Through the publications of organizations interested in crippled children, the physician can acquaint himself with the recent trends in muscle training. The Ohio Society for Crippled Children publishes a handbook[10] on physical therapy for cerebral palsy that is an excellent outline for a systematic physiotherapy program. It describes in detail rhymes, exercises, rhythm music, and useful restraints and appliances. Likewise, a handbook demonstrating improvised equipment for the physically handicapped[11] is of great help to those interested in this phase.

Occupational Therapy: This form of re-education utilizes toys and games to train the child to achieve the social amenities, as well as acquire vocational skill. It is important to use playthings of proven therapeutic value. Rogers and Thomas[12] have listed these materials for children with cerebral palsy. More recently, the American Occupational Therapy Committee published a Cerebral Palsy Round Robin Digest[13] for the purpose of recording the ideas and practices of qualified therapists. It is an unusual review and is highly recommended.

Education: Recent trends in cerebral palsy reflect the equal importance of all workers in this field. It has been proved that only with close cooperation of physicians, therapists, teachers, psychologists, social workers, and parents can a successful program be achieved. A pamphlet recently published, emphasizes this.[14] It contains an excellent list of references for those who need help in this work.

The fact that the peculiar and special needs of the cerebral palsied children are receiving more attention is evidenced by a perusal of the medical news sections of the Journal of the Americal Medical Association during the latter half of 1945. Excerpts such as these are becoming more common, "the City of New York plans a demonstration centre for the study and treatment of children with cerebral palsy"; the "Strong Memorial Hospital in conjunction with the University of Rochester Medical and Dental School plan a clinic and convalescent centre for children with cerebral palsy"; the "Cerebral Palsy Association of Rochester, N. Y. . . . a group of 95 parents of patients afflicted with the disease . . . are supporting the University project" the "Shriners of North America will expand their crippled children's program." The forming of these and other constructive programs throughout the country pertinent to the problem are indicative of the great demand for special clinics and schools for these children.

The report of the Commission for the Study of Crippled Children in New York City[15] emphasizes the lack of care given children with palsies and urges that a program be established in such a manner that physical and mental education may progress simultaneously. Since academic education cannot wait until motor patterns are established well enough for a normal school program, special classes which will account for physical handicaps must be organized. The responsibility for diagnosis and selection of children for these classes is a medical one. Cerebral palsy clinics must be organized at selected hospitals for this purpose. The report strongly urged that one school be established experimentally to serve as a demonstration centre to develop methods which may be followed by the other schools.

There are some excellent projects now in operation for palsied children. The majority have university teaching affiliations and are established from an attitude of research and demonstration. Unfortunately these centres are few.

Parents Education: The social worker has gained prominence in these new methods of approach in cerebral palsy, because it is in her sphere that parent education lies. Any program that does not have the parent as an active participant is weakened. Children with cerebral palsy respond to treatment better if their parents also receive some guidance. Parents' attendance at clinic for observation and training in physical therapy and a home program to insure the correct application of principles learned in the clinic round out an intelligent program.

Advances in Drug Therapy

New physiologic concepts in the transmission of nervous impulses to skeletal muscle have stimulated clinical investigation of drugs which facilitate this action. A review of current opinions regarding neuromotor physiology clarifies the rationale of a pharmocologic approach to the treatment of cerebral palsy. In normal skeletal muscle, tonus is a reflex contraction which depends mainly on slow asynchronous electrical discharges from anterior horn cells in the reflex arc. The motor nucleii and motor tracts of the central nervous system inhibit the overflow of these impulses and thus prevent hypertonus or spastic paralysis. Whereas it was

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previously believed that nervous impulses directly caused muscle contraction, it has now been established that they only stimulate the formation of chemical mediators which transmit this energy to the muscle fibers.[16] Specifically acetylcholine, formed at the motor nerve endings, is probably responsible for transmitting the nerve impulse to the muscle fibers. These fibers, however, contain cholinesterase which rapidly inactivates acetylcholine. Normal muscle action is dependent on this production-destruction mechanism. In abnormal neuromotor conditions, this delicate balance is impaired, presumably at the muscle end-plate itself. Experimentally, two drugs, curare and eserine (or related compounds like physostigmine or neostigmine) seem capable of enhancing cholinergic (acetycholine) action, not only in normal but also pathologic states. After adequate curarization, although the stimulation of efferent nerves will not produce muscle contraction, the liberation of acetylcholine proceeds normally in the muscle. On the other hand, neostigmine acts by inhibiting cholinesterase, which in turn, permits the accumulation of acetylcholine. Thus, both drugs, pharmocological antagonists, produce muscular relaxation which is useful in the physiotherapist's program. Obviously the answers to the physiologic action of these drugs are not yet completed, and a review of experimental data now undergoing investigation has no place in this discussion. A few newer concepts are, however, intriguing to those interested in neuromotor disorders.

Whereas the concept has been presented that curare produces muscle relaxation by preventing acetylcholine from eliciting its usual response, (rather than by impairing its formation) evidence is accumulating that curare may also act on the central nervous system cells involved in the reflex arc, and interfere with synaptic transmission within the spinal cord.[17] The effect of curare in individuals having neurological lesions is certainly out of proportion to the weakness of voluntary muscle as obtained when a similar dose is injected in a normal individual. This concept is very persuasive inasmuch as it is known that many more motor neurons are physiologically active than can be brought into action by the voluntary efforts of patients with neuromotor dysfunction. Because curare may block the disturbed function above the motor neuron it may be possible to facilitate the utilization of these surplus neurons.

A central action of neostigmine at the synaps similar to that at the myoneural junction is suspected. Clinically this is evidenced by relaxation of muscle spasm and facilitation of voluntary motion in various types of neuromuscular dysfunction with large doses of that drug.[18] The explanation of this action is not clear, but it is known that an overproduction of acetylcholine in the muscle fibers is paralytic in action.

It remains to be seen whether the future will change our concepts in the pharmocologic approach to cerebral palsy. At present, it must be emphasized that drugs with relaxing actions are useful adjuncts to physiotherapy and muscle training programs. These drugs must be non-toxic and without undesirable side effects. They must be long-lasting in action. Quinine, hyoscine and belladonna derivatives have been used on occasion with limited success. Curare (Intocostrin) and neostigmine (Prostigmine) promise to fulfill best the requirements in cerebral palsy.

Curare. Jungle curare used by the Orinoco and Amazon Indians to tip their darts and arrows has been so purified and standardized that substances which produced toxic effects not related to the relaxing action of curare have been eliminated. This purified curare is a relatively safe drug in producing muscle relaxation when used properly.

In cerebral palsy of children the intramuscular injection of Intocostrin, in a dose previously determined to give optimal response, is advocated.[19] This varies from 0.9 units to 3.3 units of curare per kilogram of body weight and may even be greater than this. Immediately after each such injection there is a short period of masked facies and unsteadiness, then a period of hypotonia and listlessness, followed by a feeling of lightness and exhilaration lasting approximately four days. The muscles of the trunk and extremities are relaxed, speech is clearer, and motor performance definitely smoother than usual.

Neostigmine. Neostigmine (Prostigmine) has long been known for its parasympathetic action in reducing post-operative intestinal and urinary bladder atony, and for its use in myesthenia gravis. A few years ago it was first used by Kabat and Knapp [20] to reduce muscle spasm in poliomyelitis. On the basis of that work, several investigators reported encouraging results with the drug in cerebral palsy.

For pediatric use, single oral doses of 5 milligrams each of Prostigmine Bromide, three times a day (later four or five times a day) may be more beneficial than larger doses.[21] The drug must be used for at least six months or until no further improvement is noted. Larger doses of oral medication, varying from 15 milligrams to 45 milligrams daily, depending upon the age of the patient, has been recommended.[22] The intramuscular injection of the neostigmine methylsalicylate, occasionally fortified by oral medication is also used.[18] To eliminate the side effects of neostigmine, such as abdominal cramps or diarrhea, atropine sulfate, 0.1 milligrams to 1.3 milligrams may be administered once daily. Response to treatment is indi-

cated by a slow but gradual decrease in muscle spasm, diminishing athetoid movements, and an improvement in speech.

Studies at Bradley Home. In Rhode Island, at the Emma Pendleton Bradley Home, prior to the discontinuance of the cerebral palsy program there in 1942, several clinical studies of the action of drugs in palsied children were made. Nichols and Warson[23] studied the actions of hyoscine, phenobarbital, benzedrine and atropine. Encouraging results were obtained with maintenance doses of hyoscine hydrobromide, in that drooling and athetosis were lessened, and relaxation and confidence increased. Denhoff and Bradley[19] evaluated curare in children in whom spasticity was prominent. By systematic adjustment of the dosage for each child it was found that from 0.9 units to 3.3 units of curare per kilogram of body weight when injected intramuscularly resulted in relaxation lasting approximately four days. No dangerous or toxic effects were noted, and the response to muscle training and the educational program was definitely accelerated. Since the obvious disadvantage of curare treatments were the repeated intramuscular injections, Press[24] studied the identical children with quinine methochloride, a drug recently synthesized and said to have a curare-like action when given orally. However, no constant therapeutic effect was noted. This was in contrast to the favorable action of curare on the same children.

Summary

1. Cerebral Palsy is a syndrome in which neuromuscular dysfunction is the outstanding symptom. Specific symptoms may be spasticity, athetosis, ataxia, rigidity and tremors, singly or in combination.

2. The diagnostic clinic depends on physicians with intimate knowledge of developmental behavior mechanisms, as well as consultant neurologists, orthopedic surgeons and psychologists. Newer aids to diagnosis include psychometric tests, electromyography and electroencephalography.

3. Functional self-sufficiency is the aim of any re-educational program. Physical therapy, utilizing relaxation, is the basis of good treatment.

4. Curare and neostigmine, as adjuncts to physiotherapy promise to be of value in cerebral palsy.

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DOCTOR'S ORDERS

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WEAN

THE VIRUS TYPE OF INFECTIOUS HEPATITIS

continued from page 504

by some strains of hepatitis virus. The long incubation period makes it possible to employ this measure soon after exposure to infection is suspected or is known to have occurred. The globulin is used in a single dose of 0.15 cc. per pound of body weight, administered intramuscularly. There is clear evidence that while a considerable proportion of inoculated subjects may be protected against some strains of hepatitis virus and that in some show that the procedure fails in infection by some strains. The fact that the results are conflicting should not deter us from a trial of the method, especially in institutional or group outbreaks.

Treatment

The experiences of the war suggest that in the past we have failed to realize the potential gravity of this disease. While it is perfectly clear that it is definitely more serious in the armed forces than it is in civil life, it is probably true that in the patient with an infection of average severity we have not paid sufficient attention to the importance of a long period of rest during convalescence, to the significance of diet, especially a high carbohydrate diet with adequate protein intake, and to the necessity of keeping the patient under careful observation during the convalescent period and for some months afterwards.

During the prodromal period, especially in patients with fever and other evidences of infection, patients actual attacks may be *mitigated,* reports the usual regime followed in infectious diseases should be adopted: complete rest in bed in a well-ventilated room, plenty of fluids, a soft, easily-digestible diet, and symptomatic treatment for respiratory or gastro-intestinal symptoms, discomfort from back or muscle aches, and insomnia.

Opinion is not unanimous as to the necessity for a high protein diet and the desirability of giving intensive vitamin therapy, especially the B complex. Some observers are insistent on the use of both these measures while others do not regard them as important.

During the icteric stage the diet should be fat-free, and throughout the disease drastic purgation is to be avoided. In the occasional patient with hypoproteinemia, serum albumen may be administered or methionine in doses varying with the severity of the disease. The use of this amino acid is based on experimental work which indicates that it protects the liver cells. In hepatitis it is given orally, from three to eight grammes daily in cases of average severity. In very sick patients from six to eight grammes daily may be given, or even as much as twelve grammes. No toxic reactions to methionine have been noted. In patients with severe dehydration intravenous infusions of glucose in saline are indicated. In patients suspected of or known to have peptic ulcers, Vitamin K may be administered during the icteric stage.

Conclusions

1. The common type of infectious hepatitis in the United States is almost certainly due to a virus or, to one of a number of closely-allied strains of virus.

2. In addition to the spontaneously-occurring disease, there is a clinically-indistinguishable type of hepatitis transmitted by the use of vaccine containing human blood, by convalescent sera, by transfusion of whole blood, serum, or plasma, and by extracted whole blood. While the transmissibility of the spontaneous disease probably ceases a week or two after jaundice appears, further information is needed as to the length of time that the virus can persist in the blood-stream of convalescents even though present information indicates two and a half months as the maximum.

3. Attacks of so-called "catarrhal" jaundice are indistinguishable from those occurring in epidemics of infectious hepatitis, and there is every reason to believe that they represent the sporadic form of the disease.

4. Pathological studies clearly indicate that there is no dividing line between the hepatic lesions of infectious hepatitis and those of acute necrosis of the liver (acute yellow atrophy). The difference between the lesions of these two clinical pictures is one of degree only.

5. There is good evidence that in patients with infectious hepatitis, liver damage often persists long after clinical recovery, and that the profession has tended to regard the disease too lightly. For some months after an attack of infectious hepatitis patients should be under observation and, if necessary, should be subjected to the graduated exercise tolerance test or should have multiple tests of liver function.

6. The prognosis of the disease, both as to mortality and complete recovery, is more serious in patients in military service than in civilians.

7. In addition to complete rest and a long period of convalescence the essentials of treatment consist of a high carbohydrate and adequate protein intake, the avoidance of fats during the icteric stage, and, especially in the more serious cases, the use of substances such as methionine, which protect the liver cells.

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"IT BECOMES OUR HIGHEST DUTY . . ."

THE Act of Independence passed by the General Assembly of the Colony of Rhode Island and Providence Plantations on May 4, 1776, two months before the other colonies united to break the bonds of European allegiance, citing the imposition of a "most debasing and detestable Tyranny", states that

"it becomes our highest duty to use every means, with which God and Nature have furnished us, in support of our invaluable rights, & privileges; to oppose that Power which is exerted only for our destruction—"

Strong words those. But the occasion called for vigorous and even violent action. The future of a people was at stake; the freedom of a man was threatened. And on the basis of such courage, strength of character and personal ambition was built the greatest nation in the history of the world.

But the greatest can become weak through failure to maintain strength of the individual as quickly as by subjugation by superior military might. Little wonder then that present day conditions continue to evoke increasing consideration of our willingness to transfer our invaluable rights and privileges to single authorities, refusing for our part to face obligations ever present and apparent.

Organized medicine has expressed no little concern in the past few years at the proposal of legislation to nationalize its ranks, and to place into operation federal compulsory medical care schemes. The opposition of medicine is not that of a craft or guild striving to maintain its individual rights and privileges. It is a far deeper, a far more comprehensive struggle. It is the struggle to preserve for all men the same invaluable rights and privileges referred to in the historic document written in this State one hundred and seventy years ago when tyranny from without our borders "instead of Protecting is endeavoring to destory . . ."

Aside from all the social benefits involved in any program of national health and welfare, there is a fundamental issue that has yet to be met. That is the question of local responsibility. All thinking today in these matters seems to be predicated on what the Federal government can or will do. The question is posed with such frequency that the individual has apparently lost sight of the fact that he and all his fellow Americans constitute the federal government.

It was heartening, in this era of Washingtonia directives, to read on May 3 of the proposal made by Senator Taft for a national health program that would place the entire responsibility on the States

continued on next page

and on the local governments. Regardless of whether the Taft health bill is superior or not to the Wagner proposal, certainly the introduction of any measure of such importance in Congress in which there is insistence throughout the program upon the State responsibility, and that the Federal government's interest is only in those unable to meet the expenses, "leaving the remainder of the population—about 75%—free to work out their own problems and lives, and free to develop and act under the same principles of freedom, energy, and initiative which have made progress possible in this country", is sound thinking if the democracy of 1776 is to survive and flourish beyond 1946.

HAPPY BIRTHDAY TO YOU, DR. HARDMAN

It was a pleasure to see Dr. Margaret S. Hardman at the Annual Meeting of the Rhode Island Medical Society, and it was an added pleasure to have a festive glass with the young lady at our symposium (from the Greek words for a drinking feast) at the Narragansett Hotel. Chronologically, Dr. Hardman is our oldest member, as she celebrates her ninetieth birthday in July. But few are younger in spirit.

We have spoken before of the good and active part that women physicians play in Rhode Island. Among a group of these who are constant attendants at the scientific meetings Dr. Hardman has been conspicuous for farther back than hardly any of us can remember. She has belonged to the American Medical Association, the Rhode Island Medical Society and the Providence Medical Association for practically the whole of this century.

Besides her routine private practice Dr. Hardman was for thirty-five years examining physician for both the Providence and Pawtucket Y.W.C.A., examining physician for the Providence School Department for many years and physician to the Doyle Avenue Home. We are also told that she was the first woman physician to go into Providence factories to advise young women about their health.

Dr. Hardman has thus had an active, worthwhile career, carried on to a period in life such as only a rare one among us can hope to reach. We are gratified by the interest she still maintains in our activities and we heartily congratulate her on becoming a nonagenarian.

DR. LULL NEW AMA SECRETARY

At the annual meeting of the American Medical Association in San Francisco the first of this month Dr. George F. Lull, former deputy surgeon general of the Army, was officially inducted as the new secretary and general manager of the Association to succeed Dr. Olin West.

In Doctor Lull the Board of Trustees of the AMA have apparently made an admirable choice for the all important position of secretary of the largest medical organization in the world. He comes to office at a time when organized medicine is facing extremely serious problems that call for strong and vigorous action. His background as a military leader with the medical forces should stand him in good stead for the tasks ahead.

For 33 years Doctor Lull served the Army Medical Corps with distinction. Early in the first World War he commanded a base hospital in Louisiana, and he later organized and commanded base hospital 35 of the American Expeditionary Forces. From 1922 until 1926 he served as director of the department of preventive medicine at the Army medical center, and three years later he was named as medical adviser to the Governor General of the Philippine Islands where he served for three years. From 1932 to 1936 he had charge of the Vital Records Division of the Surgeon General's Office. Then came a term of service as director of the department of sanitation at the Carlisle Barracks Field Service School. In 1940 he returned to the Surgeon General's Office to serve for the following three years as Chief of Personnel Service until his appointment as Deputy Surgeon General.

With such a varied and extensive career in organizational and administrative work, Doctor Lull was a logical choice to fill the office made vacant by the retirement of Dr. West. That he starts upon his new duties with the full support of the medical profession of the country is beyond question.

RHODE ISLANDERS AT AMA SESSIONS

With California but sixteen hours away by air flight, many Rhode Island physicians traveled to the sessions of the American Medical Association at San Francisco the first week of this month. At special society meetings Dr. George Waterman and Dr. B. Earl Clarke presented scientific papers, the former addressing the American Radium Society on the "Use of Long Interstitial Needles in the Treatment of Cancer of the Cervice", and the latter addressing the pathologists on "Primary Systemic Amyloidosis—Report of a Case."

Dr. Alex M. Burgess, delegate from the Society to the convention, left by motor early in June, heading first for Banff, Canada, where he represented the American Medical Association at the annual meeting of the Canadian Medical Association. From the Banff meeting Dr. Burgess headed for San Francisco where he represented our Society at the meetings of the House of Delegates of the AMA. Also at these sessions was John E. Farrell, executive secretary of the Society.

One of the outstanding scientific exhibits at the AMA meeting was that of Dr. F. Ronchese, of Providence, who presented a display on occupational marks as an aid to personal identification. The exhibit consisted of photographs and drawings showing the callouses and similar marks produced on the hands and elsewhere by the tools or machines in various trades or professions.

. . . Pro Patria . . .



CAPTAIN THOMAS A. MARTIN, MC, AUS
Died: August 4, 1942



LIEUTENANT IRVING BLAZAR, MC, AUS
Died: December 20, 1943



LIEUTENANT RAYMOND LUFT, MC, USNR
Died: June 23, 1945



CAPTAIN MILTON KORB, MC, AUS
Died: December 29, 1945

A PRELIMINARY REPORT ON THE CRAWFORD ALLEN HOSPITAL FOR RHEUMATIC CHILDREN

Lt. Walter T. Zimdahl, MC

The Author. *Lt. Walter T. Zimdahl, MC, of Providence. Chief, Cardio-vascular Service, Brooke General Hospital, Texas; Formerly Resident in Cardiology, Heart Station, Rhode Island Hospital.*

Realizing the need for well-regulated convalescent care for rheumatic children in Rhode Island, the Crawford Allen Hospital was opened for that purpose in July, 1944. To acquaint more physicians with the program and with what is being done at the Crawford Allen, a preliminary report has been prepared. As yet it is too early to draw any definite conclusion but we present this as an informative statistical report of the hospital's activity up to April 1, 1946.

Rheumatic fever and rheumatic heart disease is still one of the most prevalent diseases in children. Swift and Atwater[1] estimated about 170,000 cases per year in the United States in a population of 110,000,000. Martin[2] estimated annual deaths at about 40,000. The greatest incidence of first attacks is experienced between the ages of four to fifteen, although it may occur any time from infancy to old age. About one-half to two-thirds of those who have suffered from rheumatic fever are cardiac cripples before the age of fifty.

Rheumatic fever in children, unless acutely fatal, usually runs a subacute or chronic course. Relapses are common and of the various types of manifestation only one or two may be present, such as low-grade fever, increased sleeping pulse rate, elevated erythrocytic sedimentation rate, electrocardiographic findings, cardiac signs, failure to gain weight or loss of "pep." With each relapse there are increasing signs of cardiac damage and unless the resisting capacity of the child can be made sufficient to throw off the infection, the final picture is one of cardiac failure. If on the other hand, no additional relapses occur, many children recover without permanent cardiac damage. At the onset, it must be emphasized that institutional care is not yet the final answer or the ideal form of treatment. However, it is one of the best we have so far. And it offers great benefit to both types of patients, those in whom we hope to prevent further attacks, and those who run a long chronic course.

In 1941,[3] there were less than a thousand beds devoted exclusively to the care of rheumatic heart patients in the United States. This has increased somewhat but not as widely as it should have and must. The Crawford Allen Hospital is devoted exclusively to the treatment of rheumatic heart disease and convalescent care. It occupies a three-story brick building on the Narragansett Bay near East Greenwich, Rhode Island. It is divided into wards with eight to ten beds in each and has two isolation rooms. The hospital has a capacity of fifty beds.

The Crawford Allen Hospital is another ward of the Rhode Island Hospital and is under the supervision of the Department of Pediatrics. The Medical Staff consists of those visiting physicians on the Pediatric Staff of the Rhode Island Hospital, members of the visiting staff of the Heart Station, one house officer on pediatrics and the Resident in Cardiology at the Heart Station of Rhode Island Hospital. The nursing staff consists of trained nurses and senior student nurses from the School of Nursing, Rhode Island Hospital. The hospital does not accept acute cases but as soon as the patients recover from their initial acute stage they may be admitted. Cases of rheumatic fever with or without heart disease and cases of active rheumatic heart disease are accepted.

Both male and female patients are admitted, the only limitation being on age which is thirteen at present. Both ward and private patients are admitted. The ward patients' expenses are met by local welfare agencies and by funds from the State Rheumatic Fever Program. Patients are accepted from clinics and homes or from a general hospital. Many cases are transferred from the Potter Building at Rhode Island Hospital soon after their acute stage but while some activity is still present.

The Providence Board of Education supplies two teachers so that all children continue their school work without interruption. The children after their initial shyness soon develop a fondness for the sanatorium because of its pleasant surroundings. During the warm months, the children spend most of their time out of doors—in a bed, on the playground, or on the sandy beach. During the winter months, games and occupational therapy

occupy their time. Necessary dental work is done at the Joseph Samuel Dental Clinic at the Rhode Island Hospital while the children are at the Crawford Allen Hospital. When indications are present, tonsils and adenoids are removed during the patient's stay.

We have established classes in which the children are graded according to their rheumatic status and functional capacity. These are listed from one to six. The following is a description of these six classes.

Class I. Complete bed rest except in certain selected cases in which the patients are small then they may be (1) carried to tub for bath; (2) carried to bathroom; (3) one hour to school in cart or bed.

All patients are placed in Class I on admission after a period of isolation. The more severe cases are on complete bed rest. However, the milder cases are also put in Class I but are advanced more quickly. We have found that this arrangement has a psychological advantage.

Class II. Up only for bathroom and wash, twice daily. May be in cart for school and out-of-doors. School—two hours a day in cart or bed if not tiring.

Class III. Up for bathroom and meals only. May go out in cart. School—two hours in cart or bed if not tiring.

Class IV. Up only for bathroom and meals. Beach in cart. School, if not tiring, two hours a day. Walk to school and use blackboard. Walk in hospital and on terrace.

Class V. Out of bed. No running. Extra rest one hour and half twice daily. School three hours. Ocean bathing with care.

Class VI. No running. Otherwise no restriction of activity. One hour rest in mid-day; 15 minute rest before meals. School four hours.

According to the activity of the rheumatic infection and improvement of the patient, they are advanced through these six classes. Each patient of course is judged individually and may spend less time in some classes than others. The average length of time in the first three classes has been about three to four months and the time in the upper three classes correspondingly less. The average stay for each patient at the Crawford Allen Hospital has been 164 days or approximately 5½ months.

Blood sedimentation rates are taken on the lower three classes once to twice a week and once every two weeks on the upper three classes. The temperature, sleeping pulse and weight are also observed closely and recorded. Although it is not always the case, we have observed in most of our patients that gain in weight is parallel to the clinical improvement. The improvement in the pale, chronically-ill, underweight child has been remarkable and gratifying. Even in those patients in which severe heart damage is already present, improvement and increased resistance has been noted.

The observations in the upper three classes are equally important for here we are able to define the limitations of the patient's activity. After these closely supervised observations of the patient are made, he can then be discharged with the proper recommendations. The first eight recommendations by Hiss[4] as used by the Schools of Syracuse, New York have been helpful when discharging the patient. They are as follows: *1.* No restrictions. *2.* All gymnastics but no competitive athletics. *3.* Mild gymnastics. *4.* No physical exertion. *5.* Rest periods in school and restrictions of recess activities. *6.* School for the handicapped. *7.* Child to be furnished transportation to-and-from school by parents and *8,* home teacher. These can only be made after a careful diagnosis and evaluation of the patient's physical capacity have been made by watching the child in the last three of our six classes.

Visitors are allowed every second Sunday and are required to wear face masks. This impresses upon the parents the importance of respiratory infections. The parents are seen at this time informally by the resident who attempts to answer all questions and also acquaint the parents with the condition of their child. The parent's role in each case is carefully explained, so that when the patient is discharged the parents will have a complete understanding of the disease and further treatment of their child. All patients are discharged to their private doctor or respective clinic for further follow-up care.

Since July, 1944, 114 patients have been treated at the Crawford Allen Hospital. Of this group, 73 patients have been discharged. Their average stay was 164 days. On April 1st, there were 41 patients at the Crawford Allen. We have used the arbitrarily-divided category of (1) mild cases, in which the patient had rheumatic fever alone with no cardiac involvement, (2) moderate cases, those in whom there were present demonstrable cardiac damage or hypertrophy and (3) marked cases, in those patients where there was present severe cardiac damage such as marked cardiac hypertrophy and mitral stenosis. There were 14 patients placed in the first group, 70 in the second group and 28 in the third group on admission. Two cases of congenital heart disease were admitted. There were two deaths in the series. These two children were transferred to the Rhode Island Hospital, a few days previous to death. Both were patients with severe cardiac damage.

There were 31 cases admitted during or immediately following their initial attack. Of these, 14

continued on next page

have been discharged with an average stay of 168 days at the Crawford Allen. There was one death in this series of initial attacks.

There were 70 cases in which "polyarthritis" was the predominant initial symptom. This, however, did not consist in many cases of swollen, red-hot, painful joints but only of fleeting, aching, and painful joints and muscles. Chorea appeared in 12 cases, 11 of which went on to develop signs of rheumatic heart disease. There were 30 cases in which the complaints were of a general nature such as failure to gain weight, pallor, malaise, anorexia, low grade temperature, etc. Ten cases were associted with severe carditis. Only 3 cases were observed with rheumatic nodules.

There have been 4 readmissions to the hospital. Case 1 was an eight year old boy who had a history of rheumatic activity for one year previous to admission. He remained at Crawford Allen 187 days and improved. Sedimentation rate became normal rapidly, he gained weight and was discharged to the clinic. In March, 1946, he was readmitted from the clinic because of a daily low grade temperature. His social conditions at home were poor.

Case 2 was a six year old girl who entered the hospital August, 1944, with a history of rheumatic activity several times previously. Her first attack was in August, 1943. She remained at Crawford Allen 194 days on her first admission. She gained weight as her appetite returned and her entire picture improved remarkably. She was discharged in February, 1945, as improved, with minimal cardiac damage, and was followed by the clinic. In February, 1946, because of paleness, failure to gain weight, she was readmitted. She was found to be in a state of malnutrition. Again, her social conditions were found to be very poor.

Case 3 was a ten year old girl who was first admitted to the Crawford Allen in February, 1944, and remained 240 days. She was discharged as improved but with severe cardiac damage. On September, 1945, she was admitted to the Rhode Island Hospital with migratory arthritis and cardiac decompensation. On September 14, 1945, she was transferred to the Crawford Allen again. For several months her sedimentation time remained above 40 mm. per hour. At present she is only in class 2.

Case 4, was a ten-year old boy who entered the Crawford Allen on March 15, 1945, with generalized symptoms which were diagnosed as rheumatic fever. He remained 166 days and improved very well. He returned January 11, 1946, because of continued upper respiratory infections, failure to gain weight and increased sedimentation rate. He also had very poor social and living conditions. He has now gained ten pounds and improved generally and we are awaiting adjustment of his social affairs at home before discharging him again.

These cases again illustrate that another basic problem in attacking and fighting this disease is in the social and economic conditions. To improve this situation the cooperation of all our national, state and local agencies is needed.

A few of the discharged cases are presented briefly.

Case 1: W.D., well developed, eight-year old white male, became ill in March, 1945. The family physician observed "rheumatic nodules." The patient remained in bed for eight weeks but because of unsatisfactory progress, treatment at Crawford Allen was recommended and he was admitted June 30, 1945. There was a history of scarlet fever at the age of five. Physical examination showed a thin, well-delevoped boy with enlarged cervical glands. The heart was enlarged by percussion to the left and there was a grade II systolic murmur at the apex. P_2 was greater than A_2. The pulse was 110. The rest of the physical was negative. His red blood count was 3,810,000, white count 10,900, hemoglobin 77%. A urinalysis was negative. TB. patch test was negative. X-ray of the heart showed minimal enlargement.

On admission, the blood sedimentation rate was 30 mm. in one hour (Westergren Method). The child's temperature was 99.8° F each afternoon. This continued for about 60 days and then stayed normal. His pulse rate also dropped to 90. The blood sedimentation rate came to normal also. He remained 141 days and was discharged on normal activity. Physical examination was the same except that the patient looked and felt remarkably improved. He had gained 9.5 pounds.

Case 2. N.H., a ten-year old white male, was admitted to the Crawford Allen Hospital, October 20, 1944. In August, he had developed pain and swelling of all his joints with elevated temperature. He was kept in bed for two weeks and allowed up slowly. Since then he complained of joint pains on-and-off. With this incidence of rheumatic fever, he developed a limp, particularly in the morning. He was nervous, excitable and irritable at all times. The boy had noticed dyspnea on exertion, could not play with other children, gained no weight and had a poor appetite.

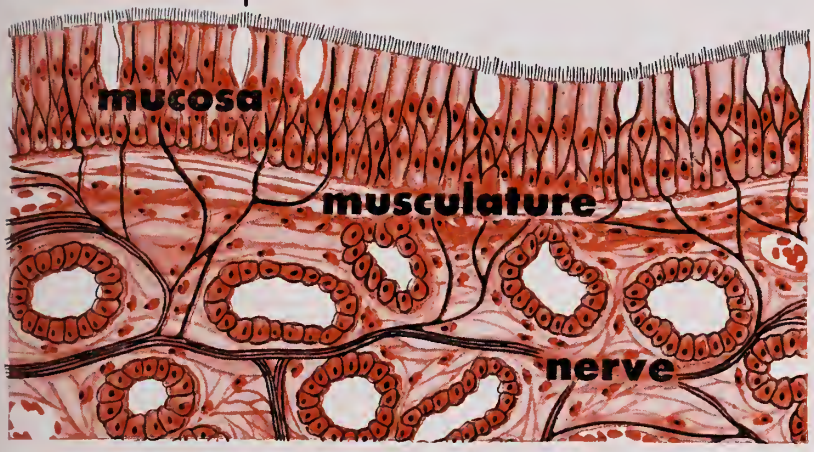
Past history revealed poliomyelitis at the age of nine and scarlet fever at five. He had always had colds and sore throats. For the past eight to ten months he had bouts of fever in the afternoon with headaches and vomiting.

Physical examination showed a pale, well-developed, poorly-nourished boy in no distress.

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respiratory mucous membrane . . .
bronchiolar musculature . . .
central nervous system . . .



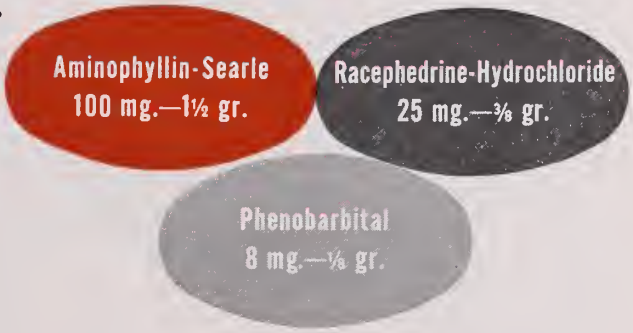
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RESEARCH IN THE SERVICE OF MEDICINE

REPORT ON CRAWFORD ALLEN HOSPITAL

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The heart was not enlarged to percussion. The rate was rapid and there was a grade III systolic murmur over the entire precordium. Slight residual weakness of the right peroneal group of muscles was present. X-ray showed straightening of the left border of the heart. His red blood cell count was 3,740,000, white blood count 8,800 and 12.1 gm. hemoglobin. His temperature rose in the afternoon for the first 70 days at the hospital. The blood sedimentation rate which was 35 mm. in one hour on admission went to 10mm. in one hour in six weeks. The patient regained his appetite and enthusiasm. While he was at the Crawford Allen Hospital, he had necessary dental work completed. He remained for 210 days. During his last month of observation, he took part in all activities with no dyspnea or other signs of limitation. The patient gained 29 pounds during his hospital stay and was discharged with recommendations against strenuous exercise.

Case 3: D.N., a nine-year old white female was admitted to the Crawford Allen Hospital, June 20, 1945. She had been a healthy child until March, 1942, when she became clumsy and awkward in school and unable to concentrate. The diagnosis of chorea was made by her physician and was kept in bed for ten weeks. After this she lost some of her "nervousness" but never gained any weight. She began to have frequent colds during the winter and the following March developed the same symptoms as previously. She was in a general hospital for two weeks and then discharged. She became worse and was followed at a clinic and was admitted to Crawford Allen. Physical examination showed a thin, pale girl with mild chorieform movements of the hands and face. There was no enlargement of the heart by percussion. A grade II systolic murmur was present over the apex. X-ray showed a normal size heart. After admission she showed a steady gain in weight which amounted to 14 pounds in her 186 days at the hospital. Her temperature which rose to 99.8° each day fell to normal in one month. Her purposeless movements disappeared and she became interested in her play activities. The blood sedimentation rate which was 30 mm. in one hour returned to normal in two months. She was discharged to the care of her physician.

Case 4: G.W., a ten-year old white female, was admitted to the Crawford Allen Hospital January 25, 1945. Previously the patient had been admitted to a general hospital with the chief complaint of headache, abdominal pain and fever for three days. The diagnosis had been mesenteric adenitis. Past history revealed that the patient had not been able to gain weight and complained of continual fatigue. Her family history showed two brothers with a positive diagnosis of rheumatic fever. Physical examination showed a well-developed, undernourished, pale girl with flushed facies. The cervical glands were palpable and her pharynx was inflamed. The heart was not enlarged to percussion but there was a grade II systolic murmur heard over the precordium, maximum at the apex. There was moderate voluntary spasm over the entire abdomen. The urine was negative. Red blood count 4,000,000, white count 13,150 with 81% polys, 19 lymphs. The blood sedimentation rate was 65 mm. in one hour. An X-ray showed straightening of left border of the heart.

The blood sedimentation rate fell to normal in 49 days and at this time she began to gain weight. Her total gain was 16 pounds in her 160 day stay at the hospital. Her general condition on discharge was better than it had been at any time previously.

Summary

All of us associated with this problem at the Crawford Allen Hospital have seen that the patients have definitely been benefited. The general well-being of the patient has been tremendously improved. Each patient must be treated individually, and this is done under the eyes of trained observers. The period before discharge is important because that is the time when we can best observe the physical capabilities of each patient and more adequately make our recommendations. The greatest potentiality of this type of treatment is in the child in whom the disease runs a chronic, subacute course. The improvement in these patients is very encouraging, although the final result can not be known for some time. I hope that more of us will become interested in this great problem of rheumatic fever and rheumatic heart disease.

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ANNUAL REPORTS . . . 1945

Rhode Island Medical Society

ANNUAL REPORT OF THE SECRETARY

The Society has continued its steady growth of membership and during the year reached a total of 726 Fellows. Since the cessation of the war all but 29 of our members have returned to practice in the State, thus materially aiding in the activation of many of the programs necessarily curtailed during the war years.

The transition from war to peace brought with it many complex problems, most important of which from the Society's viewpoint was the readjustment to civilian practice of the physician-veterans. Through the committee on War Participation, and the executive office of the Society, every effort was made to assist each doctor returning to the State.

The bimonthly meetings of the Council have been excellently supported by the councillors who have labored conscientiously and willingly on the many problems presented. The development of preliminary plans for a prepaid voluntary surgical insurance plan has added to the work of the Council and the House of Delegates which was called into three special sessions to discuss the proposed program. Detailed reports of these meetings have been recorded in the MEDICAL JOURNAL during the year that the entire membership of the Society may be informed. Likewise, reports of various committees, and actions by the Council have been reported, and therefore do not bear repetition, even in summary, in this report.

With the adoption of the recommendation made a year ago that the various committees submit their recommendations in writing to the House, the work of that body has been more efficiently carried out, and in the opinion of your Secretary the procedure is most advantageous to all delegates.

It has been a high honor to serve as the Secretary of this Society during the past five years—years that are historical for the nation as well as the Society. I am truly appreciative of the support that has always been accorded to me by the officers, the Council, the House of Delegates, and the various committees, in the discharge of the duties of this office.

Respectfully submitted,

WILLIAM P. BUFFUM, M.D., *Secretary*

May 8, 1946

ANNUAL REPORT OF THE TREASURER

Receipts

Cash on Hand, January 1, 1945	$ 7,197.14
Checks not cashed	42.40
	$ 7,154.74
Annual Dues	11,990.00
Donations	2,898.56
R. I. Foundation (For Inst. of Pathology)	500.00
Harris Fund	380.08
Terry Fund	48.00
Davenport Fund	44.50
Ely Fund	186.50
Morgan Fund	21.50
Endowment Fund Interest, Transferred to Peoples Savings Bank	85.00
Exhibits, Annual Meeting, Donations, etc.	2,062.14
Exhibits, 1946	1,387.50
	$26,758.52
Outstanding checks	95.37
	$26,853.89

Expenses

Printing and postage	$ 763.81
Gas	45.68
Electricity	99.65
Fuel	877.25
Telephone	223.97
City Water	18.18
Library supplies and expenses	710.85
Library repairs	357.71
Salaries	12,011.86
Journals, Ely and Terry Funds	84.85
Safe Deposit	7.20
Treasurer's Bond	25.00
Delegate, American Medical Association	100.00
Expenses, Meetings and Committees	494.62
Endowment Fund interest transferred to savings	85.00
Expenses of exhibits, annual meeting	1,057.53
Collector of Internal Revenue	1,177.81
Ely Fund, purchase of 15 shs. R. I. Public Service Co.	515.63
Executive Secretary, travel expenses	301.52
Insurance	793.60
Medical Library Association Dues	15.00
Office equipment	280.16
	$20,046.88
Cash on Hand to Balance	6,807.01
	$26,853.89

SPECIAL FUNDS

Interest and Disbursements

January 1, 1946

J. W. C. ELY FUND

A memorial fund established in 1912 by the son and granddaughter of Dr. J. W. C. Ely, in the amount of $1,500, to be called the J. W. C. Ely Fund and the income from which is to be used for periodicals.

37 shares, Rhode Island Public Service Co.	$ 1,071.67
Interest (Paid to R. I. Medical Society for periodicals)	89.00
*Mechanics National Bank, Common Stock, Dividends in Liquidation	520.00
	$1,680.67

**(*April 16, 1945, 15 shares of R. I. Public Service Co. purchased with dividends—$515.63*)*

continued on page 537

COMPONENT SOCIETIES BY MEDICAL DISTRICTS

Society	*Delegates*	*Councillor*	*Officers*	*Meeting Dates*	*Annual Meeting*
Kent County Medical Society	Rocco Abbate	Fenwick Taggart	President, Whitman Merrill Vice President, P. Erinakes Secretary, J. E. Vidal Treasurer, John A. Mack	2nd Thursday of each month	December
Newport County Medical Society	James C. Callahan Samuel Adelson	Norman M. MacLeod	President, A. M. Tartaglino Vice Pres., Wm. A. Stoops 2nd Vice Pres., P. P. Ciarla Secretary, H. W. Brownell Treasurer, N. U. Zielinski Censors: N. M. MacLeod John A. Young	4th Tuesday of every other month—Jan., Mar., May, July, Sept., Nov.—usually no July meeting held	January
Pawtucket Medical Association	Earl J. Mara Robert Henry Charles L. Farrell Henry Hanley	James L. Wheaton Earl F. Kelly (alternate)	President, Wm. N. Kalcounos Vice Pres., Earl J. Mara Treasurer, L. A. Senseman Secretary, K. W. Hennessey	On or after 3rd Thurs. of each month at time and place designated by the Pres. (except July-August)	March
Washington County Medical Society	Linwood H. Johnson Julianna R. Tatum	John P. Jones	President, S. P. Turco Vice Pres., Louis Morrone 2nd Vice Pres., S. A. Capalbo Sec'y-Treas., J. R. Tatum	January, April, July, October — on second Wednesday of the month	January
Woonsocket Medical Society	H. Lorenzo Emidy Francis King	James McCarthy Saul Wittes (alternate)	President, Joseph Reilly Vice Pres., Richard Dowling Secretary, Alfred King Treasurer, Paul Boucher Censors: E. L. Tremblay George Crepeau Joseph McKenna	2nd Tuesday, alternate months, Sept.-June	Elective
Providence Medical Association	Bertram H. Buxton H. G. Calder A. V. Migliaccio A. Henry Fox Arcadie Giura Alex. M. Burgess Emery M. Porter Henry E. Utter George W. Davis Kalei K. Gregory Edward V. Famiglietti Peter F. Harrington	Emery M. Porter	President, Paul C. Cook Vice Pres., Guy W. Wells Secretary, Frank Cutts Treasurer, Wm. P. Davis	1st Monday of each month; Oct. — May inclusive	January
	Frank I. Matteo E. Wade Bishop G. Edward Crane Arthur E. Martin B. Earl Clarke Paul C. Cook	Peter P. Chase J. L. Bellotti Robert H. Whitmarsh Frank Cutts Wm. P. Davis William Horan	P. I. O'Rourke Robert Baldridge George Waterman Herman A. Lawson Albert H. Jackvony		

Society	*Officers*	*Annual Meeting*	*Chairman, Elected Committees*
Rhode Island Medical Society	President, Herman C. Pitts Vice President, Michael H. Scanlon President Elect, Arthur H. Ruggles Secretary, Morgan Cutts Treasurer, Charles J. Ashworth Ass't Secretary, Charles B. Ceppi Ass't Treasurer, G. Raymond Fox	May 15 and 16, 1946 at Rhode Island Medical Society Library, 106 Francis Street Providence 3. R. I.	Philip Batchelder and Merle M. Potter, Auditors Stanley Sprague, Committee on Industrial Health Russell S. Bray, Committee on the Library Alex M. Burgess, Committee on Postgraduate Education Arthur H. Ruggles, Committee on Medical Economics William H. Foley, Committee on Public Laws Guy W. Wells, Committtee on Public Policy and Relations John E. Donley, Committtee on Publication Herman C. Pitts, Committee on Scientific Work and Annual Meeting



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ARTHUR H. RUGGLES, M.D., *Editor*

THE EVOLUTION OF THE MEDICAL RECORD*

HENRY B. MOOR, M.D.

The Author. *Henry B. Moor, M.D., of Providence. Chief, Surgical Division, The Memorial Hospital, Pawtucket, R. I.*

I HAVE CHOSEN as a subject the evolution of medical records and I might add in conjunction with that subject, evolution of man.

Having arrived in life on the unfavorable side of fifty, I, too, have shown some evolution. I presume I was one of the poorest record writers in the Rhode Island Hospital as an interne. If there is any doubt relative to this matter, as our late Al Smith oft repeated, look at the records. They still must shamefully repose in the archives of the Rhode Island Hospital. If onyone then had predicted that I one day would become interested in the writing of and improvement of hospital records, I am sure evolution would have immediately become revolution in my own mind. This is no implication upon the Rhode Island Hospital. It is a personal criticism of my own effort. I am proud to say that I had the privilege of serving as an intern in this hospital.

By this introduction, I do not intend to imply that I am today a model record writer. Far be it from such. We have in our own hospital a disease common, I believe, to most hospitals, known as chronic recorditis intercepted with frequent acute exacerbations. We, and I am sure all hospitals, are fighting this disease and making rapid progress.

This endeavor has been fathered largely by requirements of the college of surgeons which constantly tends to a betterment of the hospitals throughout the United States although I am free to admit we all complain at times of some of their directions.

The history of medical records dates as far back as 3000 B.C. Those were merely medical papyri and pictures engraved on some of the Egyptian tombs. The first actual case reports that are on record are those by Hippocrates who was born about 400 B.C. Let me quote from Dr. MacEachern's book on "Medical Records in the Hospital" a paragraph relative to Hippocrates' Histories. "Hippocrates wrote his notes in a full as well as precise manner. He recorded the patient's condition in detail including his facial appearance, temperature, pulse and respiration, excreta, sputum and localized pains and movements of the body. He did not bother with non-essentials nor did he write down meaningless words." That observation of Hippocrates coming from the present director of educational activities of the College of Surgeons to me is impressive, understanding and hopeful. So long as we have men like this at the helm we will not be burdened with pages of meaningless directives. Many lines of endeavor in this country today, in my opinion, are impeded and discouraged by such voluminous demands. May the College of Surgeons be ever mindful of Dr. MacEachern's comment on Hippocrates and keep us within the essential and out of the meaningless spheres of endeavor.

Definite and continuous records in the United States date from 1752 when Benjamin Franklin and others established the first hospital in Philadelphia which later became known as the Pennsylvania hospital. For the first fifty years the records consisted only of a hospital register with the patient's name, address, disorder, condition on discharge and dates of admission and discharge. In 1873, the hospital began to take complete histories and has a complete file to the present day.

The New York Hospital which opened its doors in 1771 now has filed away in its record department an almost unbroken series of records from 1793 up to the present minute. I was in this department within a few weeks and it alone is as large as our entire administration offices.

continued on next page

* Presented at the Annual Meeting of the Rhode Island Association of Medical Record Librarians, at Providence, May 15, 1946.



EVOLUTION OF MEDICAL RECORD

continued from preceding page

The purpose and value of medical records is now well established. The first and most important role of the medical record is to the patient himself, although, not usually as understood by him. They are of value to him only if the records are accurate, full and precise. If this premise is sound, the only way to fulfill these requirements is to have a careful and complete history and physical done on admission or within 24 hours of admission, not 24 days after discharge or not at all, as I am sure it has been in some instances in the past.

The second role of the record is the value to the hospital. The hospital today in conjunction with the attending physician is responsible for treatment, comparative work and results obtained. By the same premise as before stated, unless histories and physicals are taken within 24 hours of admission, this comparative data can mean nothing, if it is jotted down at some later date from memory.

The third role of the medical record is obvious to all, its value to the attending doctor, its comparative data in case of further sickness and its protective value to him in case of any legal entanglement.

The fourth very important role of the medical record is its value in medical research and statistics. In no instance, however, can anyone of these values be of true consequence unless the records are written promptly, carefully and conscientiously.

In 1918 the American College of Surgeons instigated a movement known as hospital standardization and adopted as one of its minimum requirements "that accurate and complete records be written for all patients, and filed in an accessible manner in the hospital."

Another very important move was made in 1928 when a group known as the Association of Record Librarians of North America was organized largely through the efforts of the College of Surgeons. I am sure you did not come here to listen to a discourse on this organization as I know you are all familiar with its principles and requirements. Suffice it to say at present certain hospitals are approved as teaching units for record librarians which courses and preliminary education leads up to the certification of members to this organization. This educational work is controlled by the American Medical Association, the American College of Surgeons and the American Hospital Association, assisted by the American Association of Medical Record Librarians.

The College of Surgeons with the approval of these other associated organizations has made certain specific rules relative to records which must be fulfilled in order for a hospital to be on the ap-

continued on page 531

ANALYSES OF NUTRITIVE VALUES:



Campbell's STRAINED BABY SOUP

	CHICKEN	LIVER	LAMB	BEEF	VEGETABLE
Solids %	11.8	13.3	13.9	13.7	13.4
Protein %	2.63	3.42	3.09	3.91	1.95
Fat %	1.5	0.9	2.1	0.9	0.5
Carbohydrate % by difference	6.4	7.5	7.2	7.6	9.3
Calories per ounce	14	15	17	15	14
Crude Fibre %	0.15	0.29	0.30	0.22	0.43
Calcium %	0.026	0.013	0.046	0.046	0.024
Phosphorus %	0.042	0.065	0.068	0.068	0.051
Iron Mg. per 100 g.	.22	.72	.35	.40	.73
Copper Mg. per 100 g.	.24	.35	.12	.17	.24
Manganese Mg. per 100 g.	.075	.173	.054	.053	.018
Vitamin A—I. U. Per 100 g.	1766	7000	1130	1693	2550
Thiamine Mg. per 100 g.	.018	.080	.036	.037	.069
Riboflavin Mg. per 100 g.	.040	.62	.068	.072	.064
Ascorbic Acid Mg. per 100 g.	1.1	7.3	2.7	3.9	7.5
Niacin Mg. per 100 g.	.77	1.54	1.22	1.29	1.05

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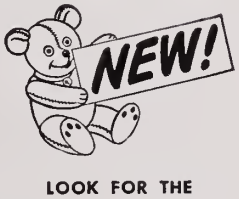
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Behind the smile of the epileptic may be the feeling of insecurity and the dread of his next seizure. DILANTIN SODIUM favorably influences such epileptic psychologic factors and is effective in controlling convulsions. This superior anticonvulsant... relatively free from sedative, hypnotic or depressant action... provides complete control of seizures in a substantial percentage of cases. In others it lengthens the interval and diminishes effects of the seizures.

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Infron Pediatric is readily dispersible in the infant's feeding formula, milk, fruit juices, or water, and can also be given in cereal.

Infron Pediatric is economical—one package contains six monthly administrations, each in an easily opened capsule container.

REFERENCES

1. Wolf, I. J.: Prevention of Rickets With Single Massive Doses of Vitamin D, J. Ped. Vol. 22, No. 4 (April) 1943.

2. Rambar, A. C.; Hardy, L. M. and Fishbein, W. I.: Hematologic and Radiologic Study of Infants Receiving Massive Doses of Vitamin D in Rickets Prophylaxis, Jl. Ped. Vol. 23, No. 1 (July) 1943.

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DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association, to which local drug and dental friends were invited, was held Wednesday, May 29, 1946, at the Pawtucket Golf Club. The annual golf tournament was a feature of the afternoon with first prize, a Tycos sphygmomanometer, being awarded to Dr. Irving Farrell. Second prize a Bard Parker sterile instrument container, went to Dr. Stanley Sprague. The putting contest was a triple tie between Dr. Irving Farrell, Dr. John O'Brien, and Mr. Thomas Simpson. A variety of door prizes was distributed to the rest of the members.

Following the banquet, the business meeting was called to order by President William N. Kalcounos. Reading the minutes of the previous meeting was dispensed with and as there was no unfinished or new business the meeting was adjourned. Thereupon, Dr. Earl Kelly presided as master of ceremonies and introduced the speaker of the evening. Lt. Commander William L. McBlain, Chaplain, U. S. N., stationed at Quonset Naval Air Base.

Chaplain McBlain, with 12 battle stars and 2 years in the Pacific, saluted the men who worked so faithfully on the home front and also those who entered the services. In particular he lauded the efforts of the Nurses' Corps and asserted that psychologically they were responsible for many cures. Relating the numerous duties of a chaplain, he summarized them by saying that to obtain the impossible, one went to the chaplain.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

The bi-monthly meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday, June 4, 1946.

The meeting was opened at 8:47 P. M. with Dr. Alfred M. Tartaglino presiding.

The minutes of the March meeting were read and approved.

The applications of Drs. John Malone, George Tollefson and Ralph Gleason, approved by the censors, were received and the three men were elected in the usual manner.

The President then welcomed the invited guests of the Society—members of the Board of Trustees and the Superintendent of the Newport Hospital.

The speaker of the evening, Mr. Kenneth D. MacColl of Providence, President of the Board of Trustees of the Pawtucket Memorial Hospital and President of the Rhode Island Blue Cross, was then introduced. Mr. MacColl spoke first of the relations of the Pawtucket Memorial Hospital and of the Newport Hospital with the Blue Cross organization, comparing the patient days paid for by the Blue Cross, the comparative costs and the amounts paid to the two institutions by the Blue Cross, since its inception. He next compared the two hospitals in size, number of beds, the number of patients treated and income received. He went on further to elaborate particularly on the sources of income of the Pawtucket Memorial Hospital, mentioning the book plan and guarantors and their recent successful professionally managed campaign for a building fund for extension of the hospital plant. Of particular interest to the members of the Society, he then spoke of the attempt being made in Pawtucket to encourage staff members to become fellows of the American College of Physicians and the American College of Surgeons and to have them become diplomates of the several specialty boards. He admitted that, at present, the number of fellows and diplomates was extremely small, but that pressure was being brought to bear, particularly upon the younger staff members by their colleagues and by the Board of Trustees, to qualify in an attempt to raise the professional standing of the institution, as a whole, and to improve its position with the various accrediting agencies. He noted that the age of retirement of chiefs of service had been raised from 60 to 62, but stated that he felt that probably this was a step in the wrong direction and this change probably would not stand. Also mentioned was the policy of appointing chiefs of staff for professional attainment, rather than for seniority.

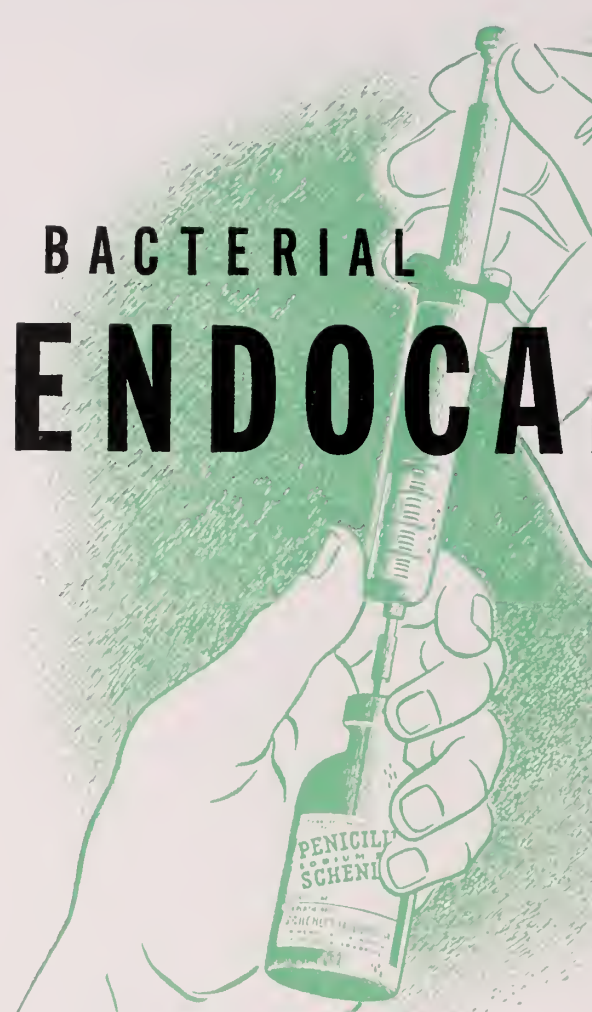
Following a general discussion, in which the members of the Board of Trustees seemed to be particularly interested in the financial aspect of Memorial Hospital's operation, while the members of the Society seemed to be more interested in the working of its staff, the meeting adjourned at 10:03 P. M.

A collation followed.

Respectfully submitted,

HENRY W. BROWNELL, M.D., *Secretary*

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Penicillin is the best agent available for the treatment of subacute bacterial endocarditis. Daily administration of 200,000 to 300,000 units or, in infections with resistant organisms, much more, in divided doses (every 3 hours) is required. Intramuscular injections are usually the route of choice; however, in certain instances, it may appear desirable to employ continuous drip. Therapy should be continued for a minimum of 3 weeks and must be continued until the blood cultures are consistently negative. Penicillin alone is as effective as penicillin and heparin combined.

Final determination of cure depends upon long-term observation, but if the patient remains asymptomatic and bacteriologically free for a period of 4 weeks after cessation of penicillin therapy, the prognosis for complete cure is excellent. However, it must be remembered that valvular damage and renal lesions are not favorably influenced.

DAWSON, M. H., AND HUNTER, T. H.: *The Treatment of Subacute Bacterial Endocarditis with Penicillin: Results in Twenty Cases, J.A.M.A. 127:129 (Jan. 20) 1945*... FAVOUR, C. B.; JANEWAY, C. A.; GIBSON, J. G., II, AND LEVINE, S. A.: *Progress in the Treatment of Subacute Bacterial Endocarditis, New England J. Med. 234:71 (Jan. 17) 1946.*

BEFORE YOU DECIDE ON THE PENICILLIN OF YOUR CHOICE

For many years, Schenley has been among the world's largest users of research on mycology and fermentation processes. In addition, Schenley Laboratories manufactures a complete line of superior penicillin products — products thoroughly tested for potency and quality. These two important facts mean you may give your patients the full benefits of complete penicillin therapy.

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EVOLUTION OF MEDICAL RECORD

continued from page 524

proved list of the College of Surgeons. The most important directions are:

(1) That records must be written within 24 hours of the patient's admission.

(2) That a patient may not go to the operating room without a complete history.

(3) Operative procedure must be written up following operation.

(4) Records must be complete and a final diagnosis tabulated on discharge of patient.

Now enough of Hippocrates, Ben Franklin, the College of Surgeons and the Association of Record Librarians. What are we doctors doing about all of this on our part.

Well, actually the improvement of doctors' records in the past five years has been stupendous but there is a long road to travel yet. It has been said that medical rules and ethics have been for the young doctor to fear and obey and the seasoned doctor to learn and forget. I am sorry to say I believe the same is true of the medical record situation today in many instances. More of the younger men are doing an excellent job. Many of the older men are still doing their records in the horse and buggy period. During the writing of this paper, I had occasion to look up an operation which was done about 10 years ago. The surgeon has since passed away. There was nothing written up on the operation and it left me with a troubled mind to know what procedure to take with this patient at present. Second and third letters of warning are sent out telling the doctor that he will not be allowed to send any more patients in the hospital, but to no avail. Just what to do about this I am not prepared to say but I do know that a child thinks a fire is pretty and something to play with until he has burned his fingers.

Recently, I was scheduled to operate in a certain hospital at 8:00 a. m. The patient came in the afternoon before and I had not written my history and physical. Upon arriving in the operating room, I was informed politely but firmly that when I had completed my chart, I would be in order for operating. My fingers were burned. I will not again play with fire and I still respect the hospital and am very grateful for the privilege of operating there.

We are at the present time doing well with our records. Most of them are written within 24 hours of admission. We are doing a rather poor job on writing our operative procedure following operation. It is my opinion that some hospitals should have a dictaphone. This is particularly true where operating rooms are not conveniently located to the record room or where it is not possible to have a stenographer posted at a desk near the operating rooms. It is true that unless people train themselves to use them correctly, they can be bothersome. On the other hand, operations are often done in the night or many times the record stenographer is busy on the floor and if a machine is convenient, I believe more of these operations would be written up immediately which is the only time to do this particular job. We are doing only reasonably well with our continued notes while the patient is in the hospital. We are not doing well at all with the discharge note and final diagnosis on the day of discharge of the patient. This last ruling is the only one that I personally feel is unreasonable. I believe there are exceptions to all rules but if a ruling is made that is more or less universally broken that ruling should be changed. We should be given 24 or 48 hours to complete and fill in the final diagnosis.

We must improve our admission and discharge diagnosis and have them correspond with the approved nomenclature. In this the record librarian is of the greatest help. This is also true of our nomenclature of operations performed. In fact I have come to the point of dictating the name of my operation and then turning to the record stenographer and asking for her approval.

We should have our diagnosis on discharge conform with the pathological diagnosis and I believe here there is room for much improvement. I find so many times the pathologist also has not conformed to the approved nomenclature.

We have now hastily spoken of the past, openly discussed the present and now just a word relative to tomorrow.

Miss Helen Lincoln, the present librarian at the New York Hospital, in a recent article entitled "Records Then and Now" and published in "The Modern Hospital" concludes with this paragraph: "I venture to say we have reached the saturation point in complex detail in record keeping and that our next important step will be simplification of systems and working routines to produce the maximum in essential data with the minimum of labor."

This is exactly my feeling at present. I want in the days to come to have a more intimate knowledge of the patient, his disease and treatment and less review of systems which are entirely irrelevant to his care and treatment. In the future: May the doctor portray a human and understanding mental picture of the patient and his treatment on paper. May the College of Surgeons give him character and relativity, and may the Record Librarian Association give him a permanent and everlasting home and always know how and where to find him.

CASH SICKNESS IN RHODE ISLAND

A Review of the Annual Report on Cash Sickness Compensation in Rhode Island and Recent Amendments to the Law

(*Prepared by* Research Council for Economic Security, *Chicago, Illinois — May 10, 1946*)

EVERY year since the start of benefit payments under Cash Sickness, the financial picture has grown progressively worse. The Tenth Annual Report of the Unemployment Compensation Board shows the gradual deterioration of the reserve fund. In 1943, there was a net increment in every quarter. In 1944, two quarters showed an increase, two a deficit. In 1945, every quarter showed a deficit.

For the year 1945, the deficit was in excess of $388,000, against a deficit of over $587,000 for 1944 or a total deficit in two years of nearly $1,000,000. The Tenth Annual Report mentions the possibility that in 1946, revenue might decline 20 per cent, while expenditures would remain at the 1945 level. In this case the deficit for 1946 would rise to $1,272,000.

When benefit payments began April 1, 1943, the reserve was about $3,000,000. At the end of 1945, it had shrunk to about $2,400,000. With a further decline in revenue but with expenditures at the 1945 level, the reserve at the end of 1946 would be down to $1,143,000, or about one-fourth of annual disbursements.

This does not mean that the Cash Sickness Plan will be abandoned. In state monopoly plans of this kind, deficits do not mean defeat, they mean only revision.

The Unemployment Compensation Board realizes the predicament. On page four of the Tenth Annual Report it states:

"Unless remedial action is taken by the legislature, the fund will, in the not-too-distant future, reach the position at which money will not be available for either the payment of benefits or for general administration.

"In its last annual report, the Board outlines some of the factors which are affecting the solvency of the fund. The additional experience which had been gained during 1945 indicates quite clearly that if the present schedule of benefit payments is to be maintained it is imperative that additional revenue be secured and that changes be made in the present eligibility requirements."

* * * *

The Research Council for Economic Security has emphasized repeatedly during the last three years that a 1 per cent payroll tax is insufficient to finance a compulsory cash sickness plan such as originated in Rhode Island. The foreign experience has been unanimous in this respect. It has been found that a payroll tax of 1½ per cent and possibly more is required.

The legislature passed the following amendments which, with the Governor's signature, became law on April 24, 1946:

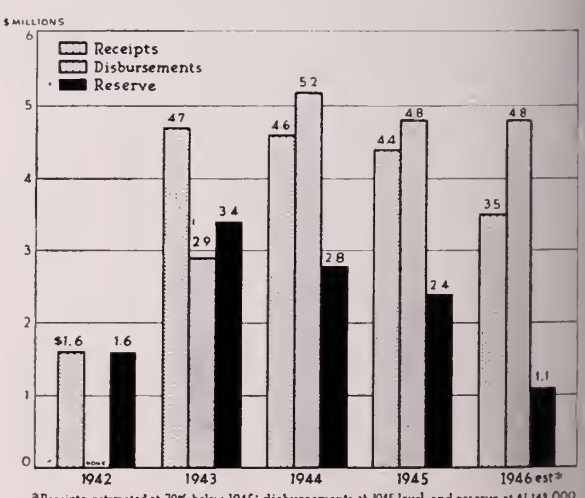
1) Those entitled to Workmen's Compensation as well as Cash Sickness benefits can receive not in excess of 90 per cent of average weekly wage.
2) Benefit period for pregnancy is reduced from 20 to 15 weeks maximum.
3) Eligibility after cessation of employment reduced from 2 years to 6 months.
4) Appropriation for administrative expense increased from 3 to 4 per cent for a two-year period beginning July 1, 1946.
5) Advisory Committee of seven members is created.
6) Remaining ½ of 1 per cent of State Unemployment Tax borne by worker is diverted from

continued on page 535

RHODE ISLAND
CASH SICKNESS COMPENSATION

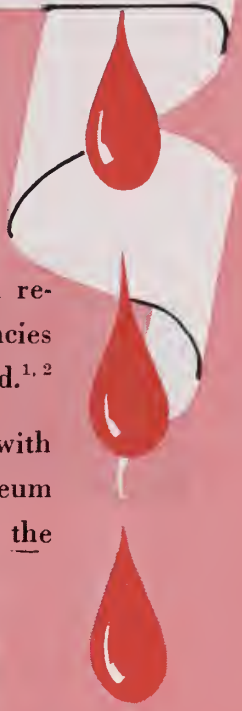
Receipts, Disbursements and Reserve

1942 - 1946



*Receipts estimated at 20% below 1945; disbursements at 1945 level, and reserve at $1,143,000

For the most common emergency of pregnancy



Threatened abortion brooks no temporizing, but demands immediate and active treatment. The outmoded "wait and watch" policy has given way to prompt injection of PROLUTON, pure crystalline progesterone, for as long as pain and spotting persist. As a result, approximately eighty per cent of pregnancies threatened with destruction have been saved.[1, 2]

After the emergency has been controlled with PROLUTON, the continued need for corpus luteum hormone may be met with PRANONE Tablets, the orally effective progestin.

PROLUTON
PRANONE

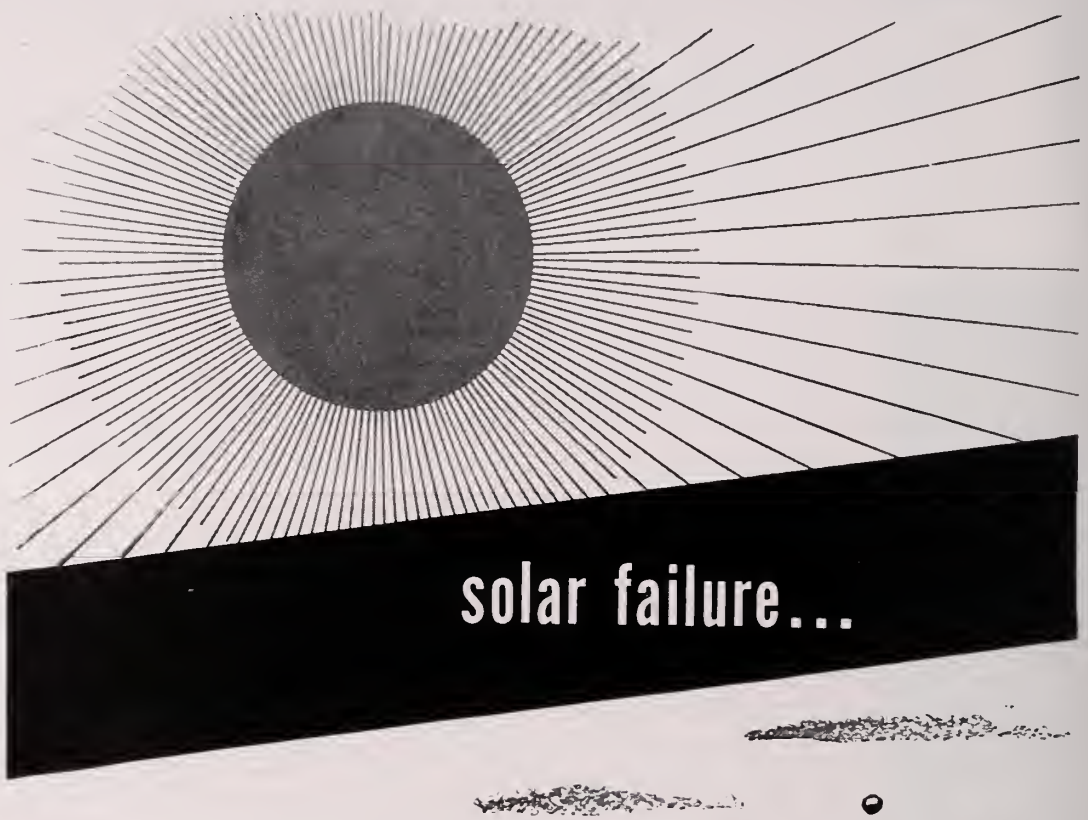
PROLUTON—pure crystalline progesterone in oil in ampules of 1, 2, 5 and 10 mg., in boxes of 3, 6 and 50.

PRANONE—anhydrohydroxy-progesterone tablets of 5 and 10 mg., in boxes of 20, 40, 100 and 250.

(1) Soule, S. D.: Am. J. Obst. & Gynec. 42:1009, 1941. (2) Mason, L. W.: Am. J. Obst. & Gynec. 44:630, 1942.
Trade-Marks PROLUTON and PRANONE—Reg. U.S. Pat. Off.

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Schering CORPORATION · BLOOMFIELD, NEW JERSEY
IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL





Florida State Board of Health findings[1] of rickets in well over 50% of 2,000 school children substantiate California reports[2] on the antirachitic unreliability of sunshine. Logic suggests supplemental vitamins the year 'round, as long as growth persists. Upjohn vitamins provide a steadfast source of potent, natural vitamin D in convenient, well tolerated form.

1. Florida Health Notes 37, May, 1945.
2 Am. J. Dis. Child. 54 1227, 1937.

Upjohn
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FINE PHARMACEUTICALS SINCE 1886

UPJOHN VITAMINS

CASH SICKNESS IN RHODE ISLAND

continued from page 532

Unemployment Compensation to Cash Sickness fund for a two-year period beginning July 1, 1946; this will raise revenue by 50 per cent.

The accompanying chart shows a decline of the reserve fund from a high of $3,400,000 in 1943, to $2.4 million at the end of 1945, and an estimated $1.1 million at the end of 1946, (at the present tax rate).

If the tax rate for the first two years would have been 1½ per cent, and for the next three years 1 per cent, the reserve fund would have reached a high of $6.5 million at the end of 1943, only to decline to $4.2 million at the end of 1946.

Obviously the legislature did not go far enough in allowing the Cash Sickness fund the additional ½ of 1 per cent tax for a period of only two years. What is required is a permanent 1½ per cent tax rate to finance the Cash Sickness Plan. If the 1½ per cent rate were applied to the five-year experience, it would build up a steadily growing reserve fund, namely:

Year	*Receipts*	*Disbursements*	*Reserve*
1942	$2,400,000	$ none	$2,400,000
1943	7,000,000	2,900,000	6,500,000
1944	6,900,000	5,200,000	8,200,000
1945	6,600,000	4,800,000	10,000,000
1946	5,200,000	4,800,000	10,400,000

The reserve fund would be necessary to meet emergencies which would probably arise sooner or later, such as epidemics, prolonged periods of depression, and others. It should also be noted that at the present time the Unemployment Compensation fund acts as a cushion upon Cash Sickness claims. But if unemployment grows large and claims rise proportionately, the effect would soon be felt upon the Cash Sickness claim rate and, therefore, upon the reserve fund. This may not seem important in the light of the large reserve built up during the war years, but it may be serious at a time of prolonged unemployment and economic recession.

Moreover, with the removal of the ½ of 1 per cent tax to Cash Sickness, the entire cost of Unemployment Compensation is borne by the employer while the cost of Cash Sickness is borne enitrely by the worker. This division may result in political differences not conducive to the efficient management of either plan.

The important lesson of the Rhode Island experience is that one per cent is not enough to finance a compulsory system of cash disability. Yet, in different states the advocates of such a system have based their arguments upon the adequacy of a one per cent tax. In the light of developments in Rhode Island as well as in foreign countries, this is an illusion and will be revealed as such whenever tried.

The foreign experience also shows a perspective not yet revealed in the State of Rhode Island. Contrary to widely held opinion, a cash disability plan opens more than merely the question of a 1 or 1½ per cent payroll tax. It opens such questions as extension of the compulsory principle: disability compensation and, eventually medical care as a public function; the growing importance of government as an entrepreneur; the excessive dependence of people upon government, and others. The broader implications point to a potential cost far greater than the financing of a single social service such as cash disability. The snowball character of that cost is clearly illustrated in the history of social security in Germany, Great Britain, New Zealand, and other countries.

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Another doctor says —

"Excellent results obtained with wet dressings of ALKALOL for Pruritus Vulvae and Pruritus Ani."

ALKALOL is comforting.

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TAUNTON, MASS.

Samples on request to doctors



Truly, this is America

the village church...the white picket fence...the broad highways which lead to great cities . . . above all, the homes which breed good citizens.

AMERICA'S strength is bred in her homes. In thousands of towns and cities, where modest bungalow stands proudly alongside a local showplace, where the well-kept lawn of one merges with its neighbor...here, the roots of good citizenship are deeply planted.

Here, too, strong bodies and good minds are built.

Because it is so American to want the finest, they will get it. In medicine, for instance, American hospitals, American practitioners are the envy of the world. In quiet towns or teeming cities, the skilled hands of healing go about their work of keeping America well.

To the science of Medicine the physician brings his own individual art of healing, for just as no two people are exactly alike, so no two cases of illness are identical.

Thus, the physician must be free and unhampered, so that he may combine the *science* of Medicine, which is for humanity, with the *art* of healing, which is for the individual patient.

At Ciba, in a quiet community of broad streets and pleasant lawns, we produce many of the fine pharmaceuticals used by the medical profession. In modern laboratories, Ciba medical scientists pursue their search for yet newer aids to physicians in their treatment of disease. This, too, is the American way.

CIBA PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

In Canada: **Ciba Company Ltd., Montreal**

ANNUAL REPORTS . . . 1945

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ENDOWMENT FUND

Started in 1912 when the Trustees (of the Fiske Fund) announced that they had voted to take the remuneration allowed them by the will, i.e. 2/12 of the annual income, amounting that year to $69.69, and present this sum to the Society to be the foundation of a maintenance fund for the support of the Library building.

16 shares, National Bank of Commerce & Trust Co.	$ 1,200.00
Interest	48.00
74 shares, Providence Gas Company	906.50
Interest	37.00
*Peoples Savings Bank	4,428.23
Bank interest and interest on U. S. Treasury Securities	61.56
	$ 6,681.29

*(*May 16, 1945. Purchased U. S. Treasury Securities, Series G. $2,000*)

E. M. HARRIS FUND

Established in 1921 by a donation of $5,000 from Dr. E. M. Harris for the upkeep of the Library building.

25 shares, Consolidated Edison Co. 5%	$ 2,346.88
Interest (Paid to R. I. Medical Society for building repairs)	125.00
74 shares, Nicholson File Co.	2,719.00
Interest (Paid to R. I. Medical Society for building repairs)	66.60
	$ 5,445.96

* * * *

FRANK L. DAY FUND

Established in 1927 by a donation from the estate of Dr. Frank L. Day to be utilized for the purchase of books.

3000 Canadian National Railway Co.	$ 2,979.75
Interest (Paid for Medical books)	67.50
Industrial Trust Company	693.62
Paid from Industrial Trust account for medical books	27.15
	$ 3,768.02

* * * *

HERBERT TERRY FUND

Established in 1928 by a donation of $2,000 from C. B. and C. H. Kenyon, in memory of Dr. Herbert Terry, for the purchase of books and periodicals and for the binding of them, for the Library.

96 shares, Providence Gas Company	$ 1,152.00
Interest (Paid out for books)	48.00
	$ 1,200.00

* * * *

JAMES R. MORGAN FUND

Established by a donation of $500 in 1929 to be used for current expenses.

43 shares, Providence Gas Company	$ 526.75
Interest (Paid out for Society expenses)	21.50
	$ 548.25

* * * *

JAMES H. DAVENPORT FUND

Established in 1930 by a donation of $1,000 for the purchase of books for the Davenport Collection (Non-medical books written by physicians).

89 shares, Providence Gas Company	$ 1,068.00
Interest	44.50
Balance on hand	868.07
	$ 1,980.57

* * * *

CATALOGUING FUND

Created by Council in 1932 when balance of fund from Clinical Conference Fund was transferred for cataloguing fund for the Library.

Providence National Bank	$ 20.92

* * * *

PARTICIPATION ACCOUNT

Providence Institutions for Savings	$ 659.47

RHODE ISLAND MEDICAL JOURNAL

Annual Report — 1945

Receipts

Advertising	$17,630.60
Subscriptions	230.00
	$17,860.60

Expenses

Printing of Journals	$10,480.93
Copyrights	24.00
Printing — miscellaneous	105.25
Postage	310.27
Refunds	39.00
Salaries and Commissions	4,000.04
Staff expenses (travel and meetings)	556.52
Supplies and equipment	439.82
	$15,955.83

Cash on hand, January 1, 1946	$ 3,036.71

CHARLES J. ASHWORTH, M.D., *Treasurer*

LIBRARY

The activities of the Library have been much increased during the past year, especially in the more recent months, with the return of the many men who were in the Armed Services. The circulation of books and periodicals is constantly expanding and the Library is called upon more and more for information, by the public at large.

The following statistics will best show the facts.

Number of Visitors 1,467 (day)

In April of this year, in response to various requests, the Library was opened from 7 to 10 P. M. on Tuesdays, Wednesdays and Thursdays. Thus far, in six evenings, there have been three visitors. This is frankly an experiment.

Books received, by purchase, from the R. I. MEDICAL JOURNAL, submitted for review, and by gifts 342

Circulation. 437 Journals; 130 books charged out and returned.

139 Journals 37 books now charged out.

Number of books in the Library not including pamphlets 34,149

Books and pamphlets catalogued to date 22,795

Journals bound and repaired 70

Inter-library loan requests 19

Journals received, subscription, gift and exchange 151

There have been added, during the year, Journal of Clinical Investigation and Journal of the History of Medicine.

continued on page 539



"Bronchial Asthma ...etiology undefined"

In the paroxysms of bronchial asthma neither the physician nor his patient can wait for full identification of all asthmagens. *Without delay, symptoms must be relieved.*

PARASMA provides this rapid, symptomatic relief by the *oral* route. It is a synergistic combination of three principal oral antiasthmatics recognized individually in the *United States Pharmacopoeia.*

The combined PARASMA formula often succeeds where its components are ineffective singly, yet it does not involve the use of barbiturates, narcotics, pyrazolons or strychnine. On request, you will receive a free, full-size trade package of PARASMA for trial in your practice.

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Each PARASMA tablet contains ephedrine hydrochloride 1/8 gr., aminophylline 1 gr. and sodium bromide 3 gr. It is *indicated* in bronchial asthma to prevent or abort paroxysmal attacks and as a sustaining therapy.

PARASMA

DOSAGE: *3 tablets with water. Not to exceed 5 tablets in 3 hours or 10 tablets per day. Intermittent courses of 5 days per week recommended. Caution — too frequent or protracted use may lead to bromism or anxiety symptoms. Contraindicated in cardiac or renal disease, hyperthyroidism, hypertension or diabetes.*

HOW SUPPLIED: *Bottles of 24 tablets.*

for symptomatic relief of bronchial asthma

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Please send literature and a free, full-sized trade package of PARASMA.

I am also interested in colonic constipation therapy. You may include corresponding material on EMODEX.

Dr. _____

Address _____

Town _____ *Zone* _____ *State* _____

ANNUAL REPORTS . . . 1945

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The following gifts are acknowledged with great appreciation:

Journals and pamphlets from Drs. Corrigan, Hammond, Kramer, Mowry, Partridge and Welch.

Books: From the Estate of Carl R. Doten, M.D. ..... 155 volumes
From the Estate of W. R. McGuirk, M.D. ..... 71 volumes
From Emery M. Porter, M.D. ..... 65 volumes
From Frank T. Fulton, M.D. ..... 11 volumes

New books have been purchased, as has seemed desirable, and as have been suggested by various Fellows. In this connection, it may be emphasized that requests for the addition of new books are always welcomed. Only through the interest of the Fellows can the Library keep abreast of the new literature in the many fields of medical science.

HERBERT C. PARTRIDGE, M.D. (*Chairman*), LOUIS E. BURNS, M.D., MEYER SAKLAD, M.D.

MEDICAL DEFENSE AND GRIEVANCE

No cases have come before this Committee except one which has been brought up in the past few days and cannot be reported in this year's business.

The Committee earnestly desires that the Fellows of the Rhode Island Medical Society should be sure that their insurance policies are adequate for any claims that may be filed against them for malpractice. It is expected that following the war a wave of malpractice suits will spring up over the entire country. Such litigation has been in abeyance during the war. It is also advised that insurance should be written for larger amounts since the ad-dammum will be higher in the future. This is in line with the increase in income and cost of living since the war. The public has become accustomed to thinking in terms of billions rather than millions.

ROLAND HAMMOND, M.D., *Chairman*, NORMAN S. GARRISON, M.D., JOHN E. RUISI, M.D., FENWICK G. TAGGART, M.D., JAMES L. WHEATON, M.D., ROBERT H. WHITMARSH, M.D.

MATERNAL HEALTH

The Committee on Maternal Health reports a total of 13,622 live births in Rhode Island during the year 1945, and during the same year a total of 16 maternal deaths, for a maternal death rate of 11.7 per 10,000 live births. Because of the lack of personnel to make a study of the causes of maternal deaths reported the Committee is unable to furnish this information as part of this report.

JOHN G. WALSH, M.D. (*Chairman*), EDWARD S. BRACKETT, M.D., BERTRAM H. BUXTON, M.D., JAMES C. CALLAHAN, M.D., CRAIG S. HOUSTON, M.D., JOHN F. MURPHY, M.D., RICHARD H. DOWLING, M.D., WALTER J. DUFRESNE, M.D., FERNALD C. FITTS, M.D.

PUBLIC LAWS

The requirement that the special survey laws commission submit in legislative form its study of a recodification and revision of the health laws at the 1946 session of the General Assembly probably halted the introduction of some health measures. Yet, in spite of the existence of this Commission, an act to license naturopaths, one to establish a state cancer hospital, one to provide an appro-

continued on next page



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Electric-Aire Electric Deodorizer

The Electro-Aire actually manufactures ozone, the element that makes mountain air so fresh. For a very low operating cost, you'll eliminate office or home odors. Colors: walnut, green, maroon, white. Size: 6½ x 5 x 4½ inches.

$23.50

Tilden-Thurber

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Newport

ANNUAL REPORTS . . . 1945

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priation of $125,000 for school health programs, and one aimed at anti-vivisection were placed before the Legislature. All four of these measures failed of passage.

The Health Code of 1946 was presented to the Assembly in the final weeks of the session. The Society had not previously seen the legislation, and therefore it requested a printing of the act which covered 569 printed pages. The Committee on Public Laws met twice within a week and carefully reviewed the proposed legislation. The findings of the committee were transmitted immediately to the Joint Committee on Health of the General Assembly. Three minor amendments were accepted by that committee, and the act was passed by the House. It was denied passage in the Senate on the grounds that it was a voluminous act making many changes in the existing laws, and its introduction at such a late date in the session did not permit careful study of it by the members of the Senate. The Survey Laws Commission was continued until February, 1947, by special legislative enactment, and the Health Code will be further reviewed during the intervening months preparatory to its re-introduction at the next session.

Amendments to the cash sickness act, including one relating to the definition of "sickness" were passed by the Assembly. These amendments have been published in the R. I. Medical Journal.

Among the measures of particular interest to physicians that were passed by the Assembly were the following: An act authorizing the cities and towns of the state to control air pollution; amendments to the cash sickness compensation plan; an act authorizing the incorporation, as a non profit organization, of the Kent County Memorial Hospital, with the officers of the Kent County Medical Society as the incorporators; and a resolution calling for a study commission to determine the advisability of a state hospital on the island of Block Island.

William H. Foley, M.D., *Chairman*, Herbert E. Harris, M.D., James H. Fagan, M.D., John F. Kenney, M.D., William P. Buffum, M.D.

SOCIAL WELFARE

The Social Welfare Committee of the Rhode Island Medical Society has been in conference with the representatives of the Rhode Island Department of Social Welfare in an attempt to improve the medical care given to public assistance recipients. The State Department of Welfare has asked your committee to clarify,

1. The basic cost standards of physicians services, together with the cost standards for medication furnished by physicians, and payment for travel by physicians in rural areas.
2. The problem surrounding the proper identification of specialists in the field of medicine.
3. The cost standards for services and supplies provided by Optometrists and the standards for referrals from Optometrists to Ophthalmologists.
4. The attitude of the Rhode Island Medical Society concerning the East Providence, Warren, Bristol medical care experiment.

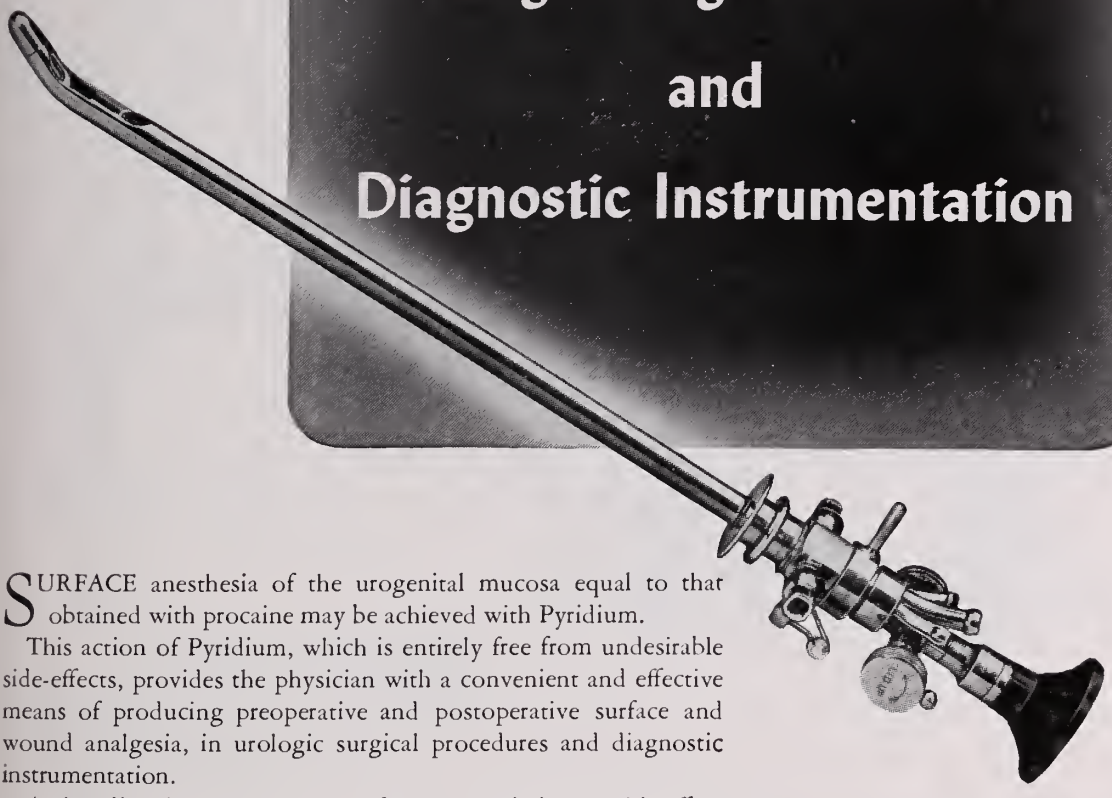
In an earnest effort to aid the recipients of public assistance and facilitate the administration of their care, your committee respectfully presents for your approval the following recommendations:

1. *Regarding fees:*

Visit to home within the community	$4.00
Night visit away from office before 11:00	5.00

continued on page 543

Effective Urogenital Analgesia in Urologic Surgical Procedures and Diagnostic Instrumentation



SURFACE anesthesia of the urogenital mucosa equal to that obtained with procaine may be achieved with Pyridium.

This action of Pyridium, which is entirely free from undesirable side-effects, provides the physician with a convenient and effective means of producing preoperative and postoperative surface and wound analgesia, in urologic surgical procedures and diagnostic instrumentation.

Acting directly on the mucosa of the urogenital tract, this effect of Pyridium is entirely local. It is not associated with or due to systemic sedation or narcotic action.

The lack of toxicity characteristic of Pyridium permits its administration virtually without consideration of toxic effects.

Pyridium imparts an orange-red color to the urine. It also temporarily stains the urogenital mucosa, which may at times make it more difficult to detect inflammatory and other changes.

For cystoscopy, cystoscopic diagnostic procedures, and for urethral medication, one ounce of Pyridium Solution is injected into the urethra and bladder and held in place with the urethral clamp for a 10-minute period. The solution then is released and a repeat injection of 15 cc. is made and retained for 5 minutes.

★ *LITERATURE ON REQUEST* ★

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For gratifying relief of distressing symptoms in urogenital infections.

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There is a margin of safety, too, well beyond optimal needs, in Vi-teens Homogenized Vitamins (especially palatable in milk, water, or formula) and in Vi-teens Super Potency tablets.

One Teaspoonful of Vi-teens Homogenized Vitamins supplies the following:	FORMULA	Two Vi-teens Super Potency tablets daily supply seven vitamins in these amounts:
1 Milligram	Vitamin B_1 (Thiamin HCL) (2666 U.S.P. Units)	8 Milligrams
1.5 Milligrams	Vitamin B_2 (G) (Riboflavin)	4 Milligrams
4 Milligrams	Niacinamide (Nicotinamide)	30 Milligrams
———	Pyridoxine (B_6)	2 Milligrams
40 Milligrams	Vitamin C (1500 U.S.P. Units)	75 Milligrams
3000 U.S.P. Units	Vitamin A	5000 U.S.P. Units
800 U.S.P. Units	Vitamin D	1000 U.S.P. Units



LANTEEN MEDICAL LABORATORIES, Inc. . . . . CHICAGO 10

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Night visit away from office after 11:00	6.00
Office visit with treatment	3.00
Visit out of the city for examination or treatment, in rural areas only	Fee visit plus 75 cents per mile
Consultation	10.00

A similar schedule of fees has been established in Michigan where it applies to all governmental and Veterans organizations. It is our feeling that this fee schedule should be established in Rhode Island. If this fee schedule is established, it is expected that the public assistance recipients will be able to receive better quality medical care since they will be in the same category with any other groups in the community. It is our intention that these fees include whatever usual medication will be given to the patient at the time, in other words, these fees are for examination with or without treatment. They are set forth for general practitioners only.

The Division of Public Assistance due to a limited appropriation, apparently is not now able to recognize these fees immediately. Many of the cities and towns in the State, however, have been paying similar rates which are above the standards set by the Division of Public Assistance.

2. *Specialists:*

It is requested, that when the classification of specialists is completed, that their identification be made known to the Department of Social Welfare, either directly, or through your Committee on Social Welfare.

3. *Ophthalmologists — Optometrists:*

Where possible all patients needing eye care should be referred to Ophthalmologists. However it is imperative that all persons under 16 years of age needing glasses for the first time should be seen by a Ophthalmologist and not an optometrist. All persons whose vision cannot be corrected to 20/30 should be seen by an Ophthalmologist.

4. *East Providence-Warren-Bristol Medical Care "Experiment":*

The East Providence-Warren-Bristol Medical Care "Experiment" has operated in these areas during the war years without criticism by physicians participating in it. It may well be the best manner of conducting the medical care program. Your committee feels, however, that this is not the time to recommend its extension throughout the State. During this period of transition to normalcy, the true value of this plan may be properly appreciated.

There is an excellent attitude by the Department of Social Welfare toward the quality of medical care administered to public assistance recipients. We have found their representatives to be cognizant of the wide variety of problems ever present in a medical care program. The administration of this program should receive the commendation of the Rhode Island Medical Society.

PETER F. HARRINGTON, M.D. (*Chairman*), HARTFORD P. GONGAWARE, M.D., EARL J. MARA, M.D., JOHN H. O'BRIEN, M.D., JAMES C. CALLAHAN, M.D., JOSEPH W. REILLY, M.D., ROCCO ABBATE, M.D., WILLIAM O. RICE, M.D.

TUBERCULOSIS

The Committee on Tuberculosis has had two meetings during the past year. The matters that came up for discussion were:

1. Whether or not personnel turned down or discharged

continued on page 548

FOR CLIMACTERIC CONTROL

Schieffelin BENZESTROL
(2, 4-di (p-hydroxyphenyl) -3-ethyl hexane)

- Dosage to Meet the Patient's Needs
- Proven Clinical Potency
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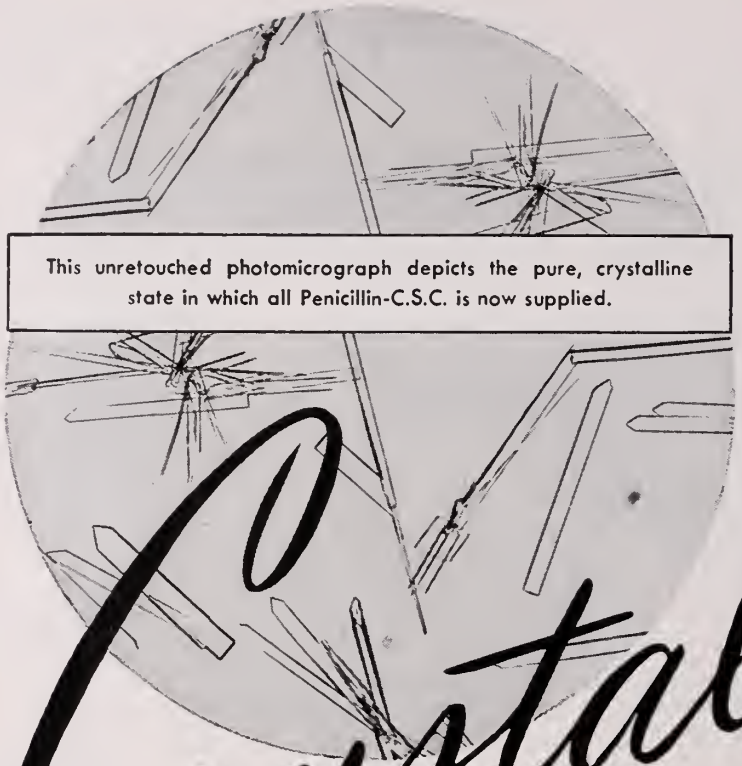
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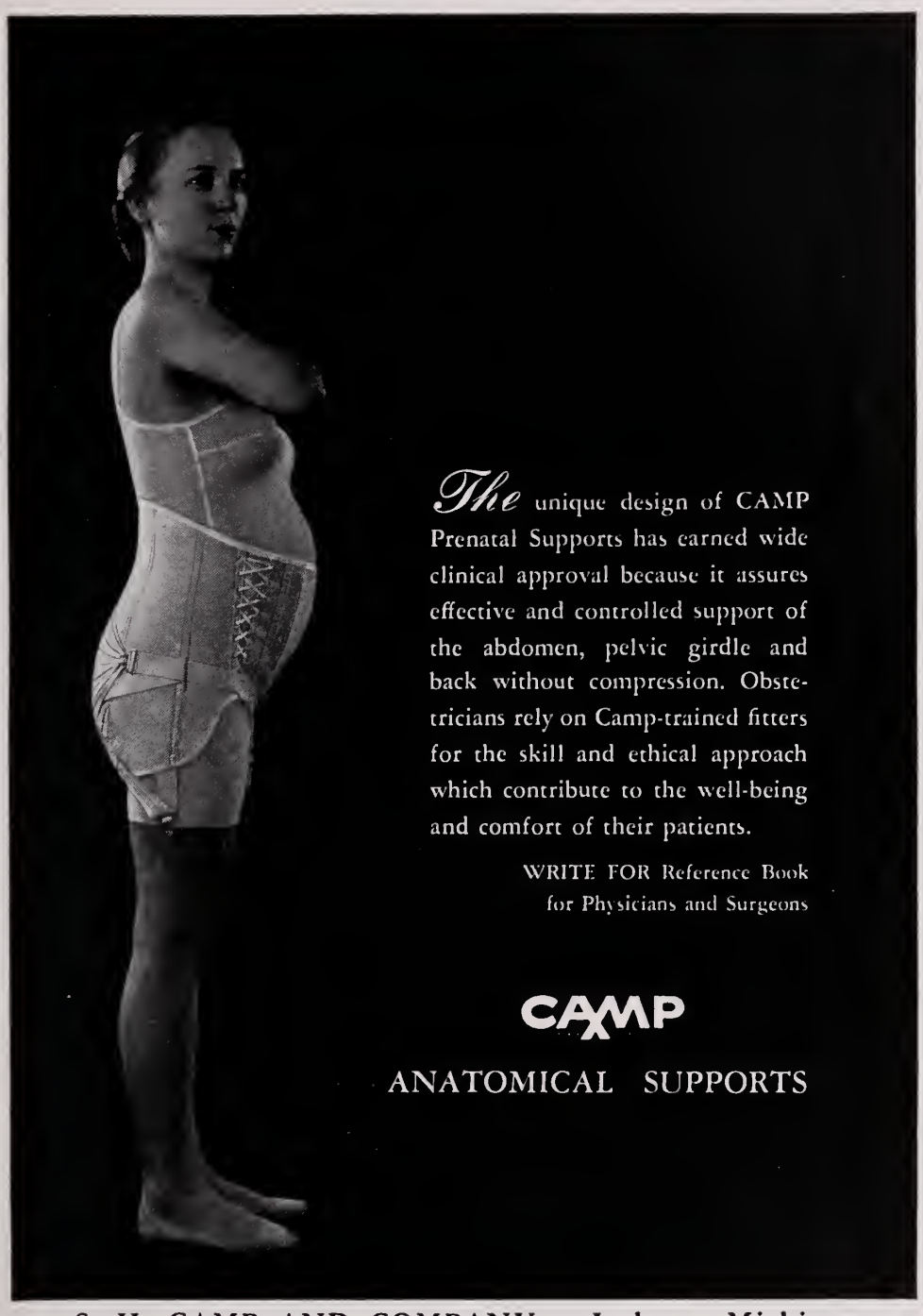
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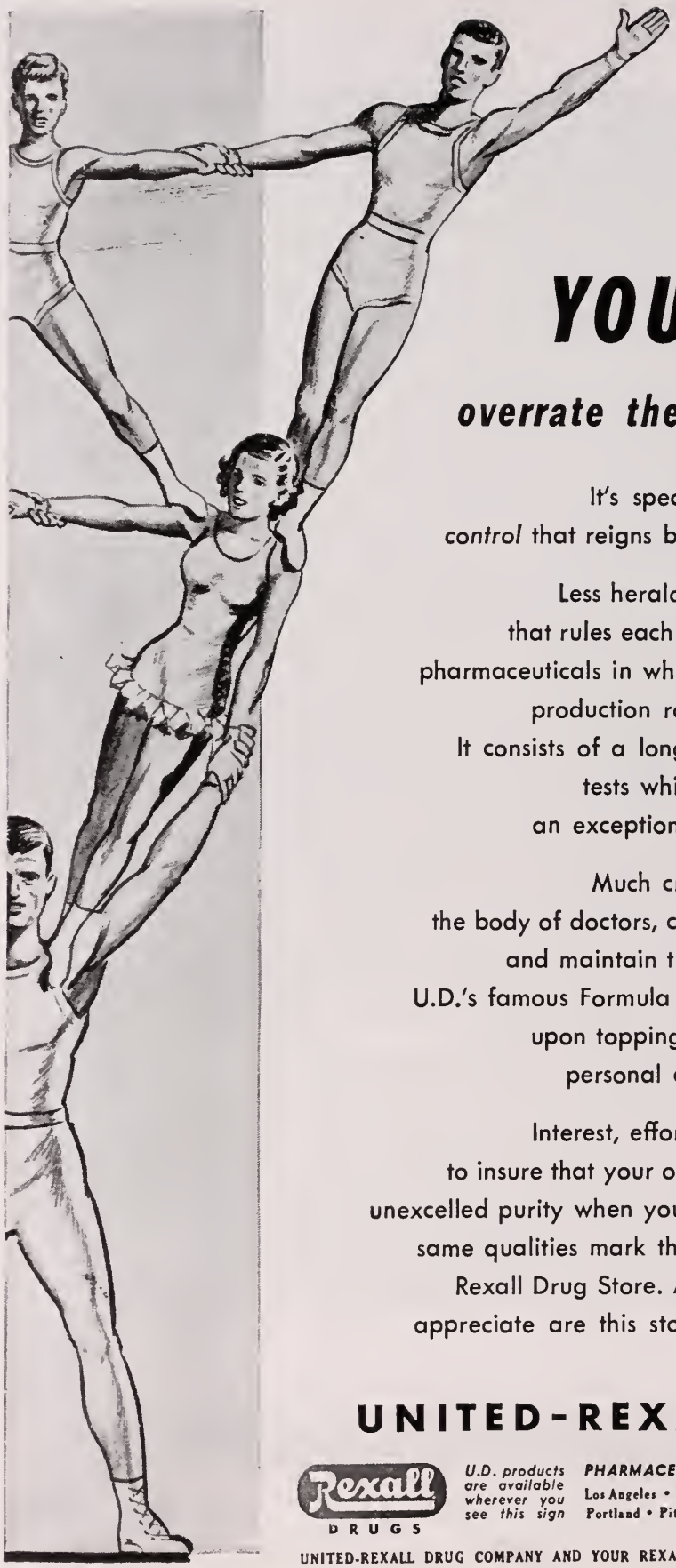
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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

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ANNUAL REPORTS . . . 1945

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by the armed services because of tuberculosis were reported to proper local health authorities.

2. Whether the cases of tuberculosis discovered on routine x-raying at Walsh-Kaiser were being followed.
3. Whether or not the present system of reporting tuberculosis in civilian practice was adequate.
4. Progress in industrial preemployment examinations.
5. The status of care of tuberculosis in Rhode Island.
6. Tuberculosis education.

It was felt that the local induction authorities had been very cooperative in reporting their cases of tuberculosis, but that since the transfer of the induction center to Boston, the reports had not come through so well and that for the men that had been discharged from service, chief reliance for reports rested with the civilian physicians whom the discharged veterans consulted.

The cases found at Walsh-Kaiser have apparently all been reported and followed either by local physicians or by one of the tuberculosis clinics of the city or state.

In regard to the reporting of tuberculosis by civilian physicians, it was felt that frequently the physicians were remiss, and that some system to stimulate the reporting would be advisable.

It was the consensus of opinion that the blanks for reporting should be simplified and that one blank should be used for all reportable diseases. It was further suggested that some penalty might be imposed by proper authority on those who failed to comply with the regulations or some compensation provided for those complying.

In regard to preemployment and routine x-raying in industry, Dr. Pinkney reported that the demand for the use of the mobile unit is becoming more general and that certain labor organizations are taking a more favorable attitude toward it than formerly. Dr. Merlino reported that further ground work had been done in regard to screening for pulmonary tuberculosis. He outlined a program for the use of two 70 mm. photofluorographic units to be run by the State Tuberculosis Division, one of which will be mobile and will be used in industrial and school surveys. The other unit will be set up in the State Office Building or other satisfactory location with the intention that it be used for preemployment and any other general screening that appears to be practical.

There are many problems that militate against the ideal functioning of the State Sanatorium, some of which are beyond immediate control, the chief of which is apparently economic. This economic problem concerns both patient and hospital personnel. Many patients refuse proper care because adequate support for their families cannot be obtained during the period of enforced rest. Because of the scarcity of trained personnel of all types and the rising wage scale, there is a serious problem in maintaining desired facilities. It is felt that the hospitals for acute diseases in the state could relieve the pressure considerably if they would carefully rule out nontuberculous disease before requesting transfer to the Wallum Lake Sana-

continued on page 550



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ANNUAL REPORTS . . . 1945

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torium. There is also the problem that an appreciable number of patients are by personality not adaptable to institutional care. Family physicians and social workers can be of vast assistance in many cases by familiarizing themselves with the sanatorium and home problems and assisting the patients and their families in meeting them. Frequently careful explanations and encouragement go a long way in alleviating trying circumstances. More general cooperation of the physicians and patients of the state with the health authorities would greatly facilitate the follow-up of known cases of tuberculosis.

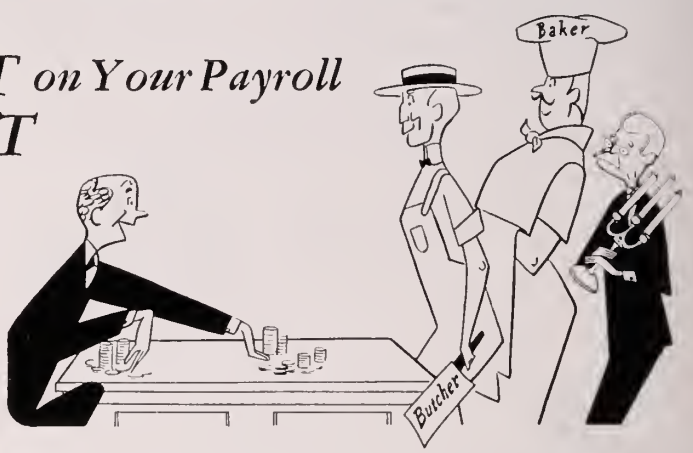
To assist in the education of medical personnel in training in Rhode Island your committee sponsors the circulation to the resident staffs of hospitals two pamphlets, "Chest X-ray Interpretation" by J. Burns Amberson, Jr. and "Diagnostic Standards and Classification of Tuberculosis" published by the national society. To further education in regard to tuberculosis in general a search is being made for a public relations man to work on this phase in Rhode Island.

We again discussed and reapproved a previous motion that there be at least one talk on tuberculosis on the calendar of the local medical societies each year.

JOHN C. HAM, M.D., *Chairman,* ROYAL C. HUDSON, M.D., DANIEL A. SMITH, M.D., PHILIP BATCHELDER, M.D., KATHLEEN M. BARR, M.D., CHARLES L. SOUTHEY, M.D., PETER F. HARRINGTON, M.D., UBALDO E. ZAMBARANO, M.D., JAMES P. DEERY, M.D.

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MEDICAL NEEDS OF THE RURAL COMMUNITIES

(An address presented to the Council of the New England Medical Societies at Concord, New Hampshire, June 9, 1946, by George M. Putnam, President, Farm Bureau of New Hampshire; Director, National Farm Bureau.)

I APPRECIATE your invitation to discuss with you the "Medical Needs of Rural Communities." Maintaining the health of rural people has been a subject of great concern to our organization—The Farm Bureau—almost from its inception.

In 1927 the women's branch of the American Farm Bureau Federation had as the subject of its annual speaking contest—"Better Health for Rural America." In preparation for this contest farm women from twenty-five states studied this problem and debated such significant questions as "How shall the sick be helped? How shall the doctor be paid."

In the prize winning essay submitted that year the speaker cleverly referred to the old poem "Which Shall It Be?" then continued with the story of a father and mother taking a survey of their children as they lie asleep, trying to decide which one they would give away for a sum of money. The question was asked, would you care to make a survey of the children of your home or your community and see which one you would be willing to lose in either rural or urban America for the sake of saving money. The need for adequate health protection applies alike to rural and urban areas.

In 1945 our annual meeting again adopted the following resolution in support of a program to bring about better health facilities for rural areas:

"One of rural America's most urgent problems is to provide a program to bring about better facilities in rural areas for hospitals, medical care and improved health. It will take the combined efforts of the medical profession and rural people to solve the problem.

"The solution must provide for comprehensive health education, for well trained doctors, dentists, nurses, technicians and laboratory scientists, as well as the establishment of Public Health Centers, hospitals and clinics accessible to all sections of rural America.

"The care of our former service men and women, of the mentally sick and the indigent and the control of communicable disease is a public obligation and should be supported from public taxation. In some communities after careful surveys it may be found advisable to use Federal grants-in-aid to assist groups to erect and equip hospitals. These must be controlled by the local people themselves.

"We believe in the extension of voluntary group prepayment services on some type of an insurance plan that provides greater flexibility and would be more likely to succeed over a wide area than rigid uniform plans on a compulsory basis. We believe that a plan which will provide for prevention as well as curative measures and the right of the free choice of doctors should be zealously guarded."

The American Farm Bureau has established a Medical Care Committee that has been and is very actively engaged in a study of this problem of rural health and in many states similar committees have been created who are cooperating with this committee. The National Committee has met with a representative Committee of the American Medical Association and during the discussion it was informally agreed that some of the existing needs are:

(1) A constructive, agressive program for medical services on a voluntary basis.

(2) Local participation and local control of any medical care program.

(3) Physicians' services in rural areas with sufficient income and availability of facilities will be required.

(4) Attack on the whole health problem including preventive as well as curative, to reach the entire population.

(5) An evolutionary program but not revolutionary.

(6) Adequate surveys.

The Medical Association Committee also agreed on suggestions made by the Farm Bureau Committee as follows:

(1) That the A.M.A. urge State Medical Associations to cultivate better working relationships with State Farm Bureaus.

continued on page 556



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THE VIRUS TYPE OF INFECTIOUS HEPATITIS

concluded from page 510

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MEDICAL NEEDS OF RURAL COMMUNITIES

continued from page 553

(2) That all committees—National, State or community selected or appointed have qualified farmer representatives.

(3) Work with medical profession in combating socialized medicine by promoting an agressive constructive program.

(4) Determine the need on factual basis after thorough consideration and research of the need for hospital and medical services with particular reference to rural areas.

(5) That the American Farm Bureau and State Farm Bureaus assume active leadership in working out plans for wise, effective use of public funds for improvement of public health with emphasis on local participation and local control.

(6) That some plan be worked out to assist in providing scholarships or loan funds for worthy rural youth to make it possible to study medicine with or without agreement to return to the country for practice.

(7) One of the problems in medical care for rural people is payment. We urge the development of prepayment medical and hospital care on a sound actuarial basis without subsidy.

Of course the discussion of problems by the National Medical Association and Farm Bureau Committees were on a national basis and related to conditions in the country as a whole. Fortunately on many of the things that were suggested by the Conference action has already been taken in this state and the Farm Bureau and our State Medical Association have cooperated in securing the improvements that have already been made, but much still remains to be done. This is especially true as applied to many rural communities. We have Blue Cross well established and more recently Blue Shield has been organized and is now available.

The situation with reference to local physicians in rural towns has been gradually growing worse. If you will pardon a personal reference I well remember when in my own town of Hopkinton we had four physicians, two in Hopkinton Village and two in Contoocook and until very recently we have been without a physician for a considerable time until recently one established an office in Contoocook and to say it mildly, the people of the community feel greatly relieved. But what of the small rural communities farther removed from urban centers where physicians are less available and where the cost of medical service from these urban areas to many of these rural families would be prohibitive.

Is it an obligation of Government to see tha funds are provided to insure medical service fo all citizens wherever they may reside? If so, hov is the cost of this to be met? In a few instance towns have appropriated funds to supplement th income of the resident physician—Is this the bet ter way to meet the situation? Or is it an obligatio of the state to accept the responsibility of establish ing a health program that is available to all its citi zens wherever they may reside?

These are only a few of the questions that migh be raised with reference to the all important ques tion, the health of our people. We are far bette situated here in New Hampshire and New Englan than are the people of some other sections of ou country. This raises the question of what shoul be the responsibility of our Federal Governmen in this connection?

I think we can agree that whatever is done b either State or Federal Government it should b on a voluntary basis and under state or local con trol. If the Federal Government is to support suc a program it should be for the purpose of correctin the inequalities that now exist in the cost of such program as between the states and in the financia ability of the states to assume such costs. Th health of our people is one of the most importan factors and will have a great influence on the futur of our nation. We must give this important subjec the consideration it deserves. Farm Bureau, a organization representing a million farm families is deeply concerned with the problem of publi health and we extend to you our full cooperatio in the development of a constructive program fo improving the health and vitality of all our people

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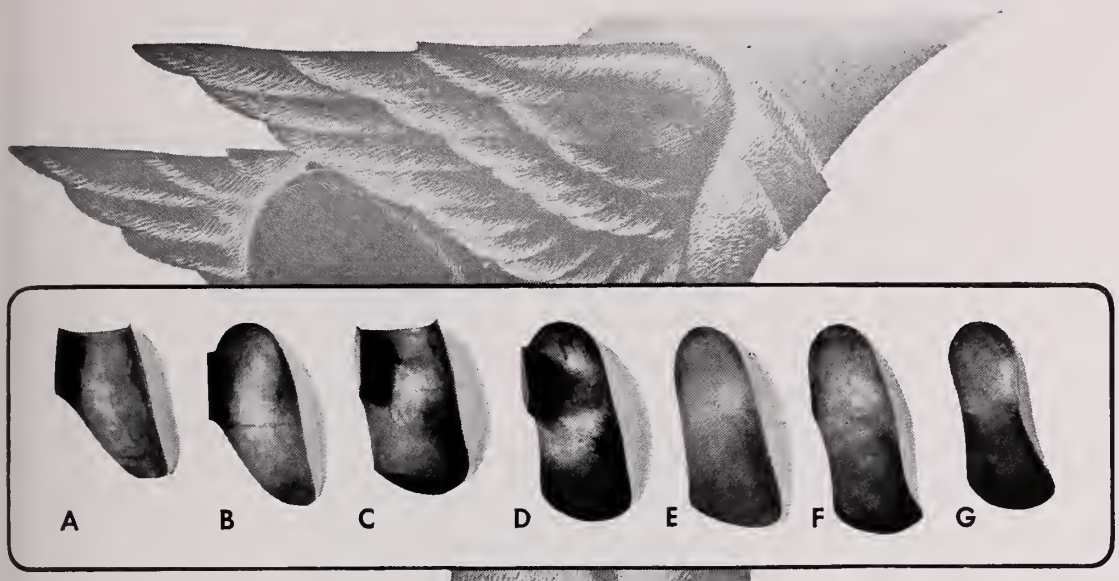
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*Reprints of the paper on this subject which appeared in The Journal of the National Association of Chiropodists, Jan. '46, will be furnished on request.

†Typical examples: A. Whitman rocker appliance; B. Modified Whitman with heel cup; C. Modified Whitman with metatarsal raise; D. Modified Whitman with heel cup and metatarsal raise; E. Simple foot plate; F. Combination metatarsal and longitudinal arch appliance; G. Metatarsal appliance.

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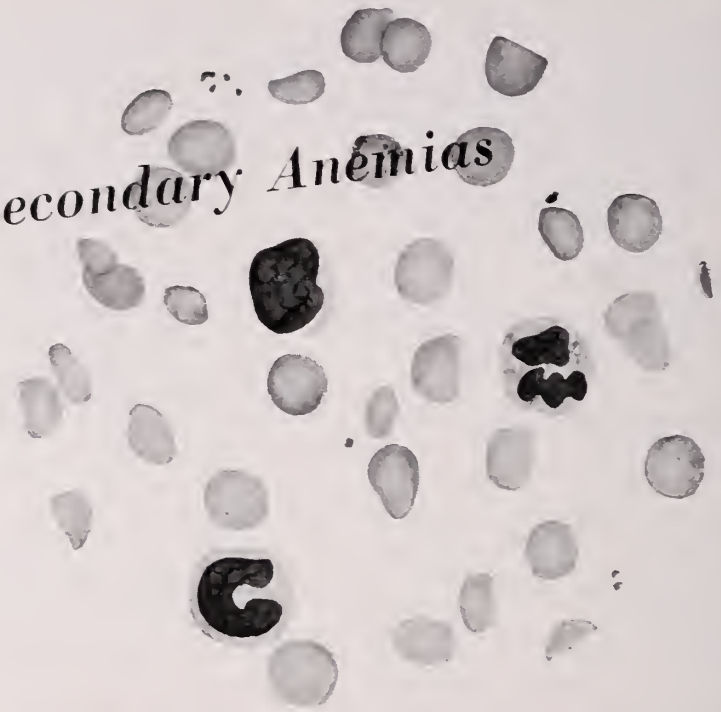
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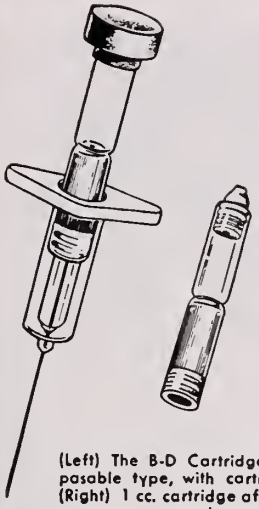


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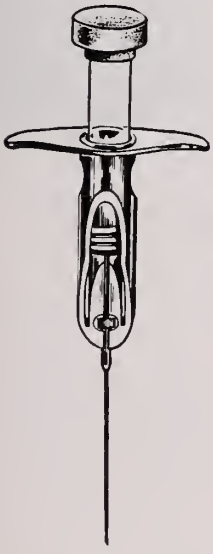
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Volume XXIX. No. 8

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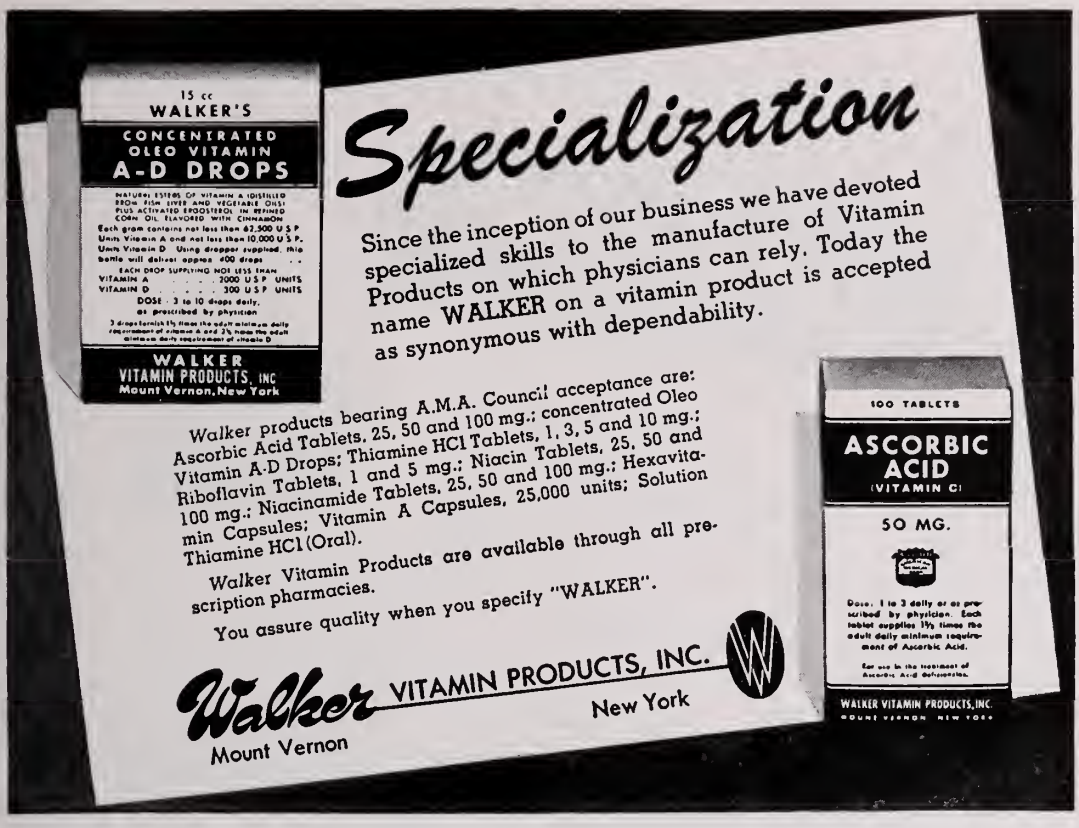
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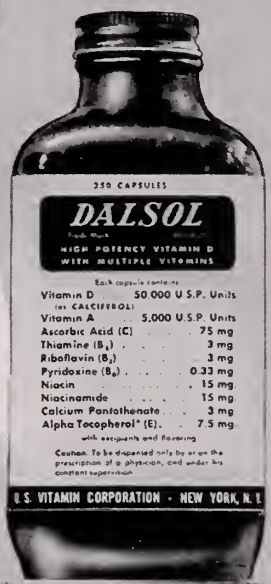

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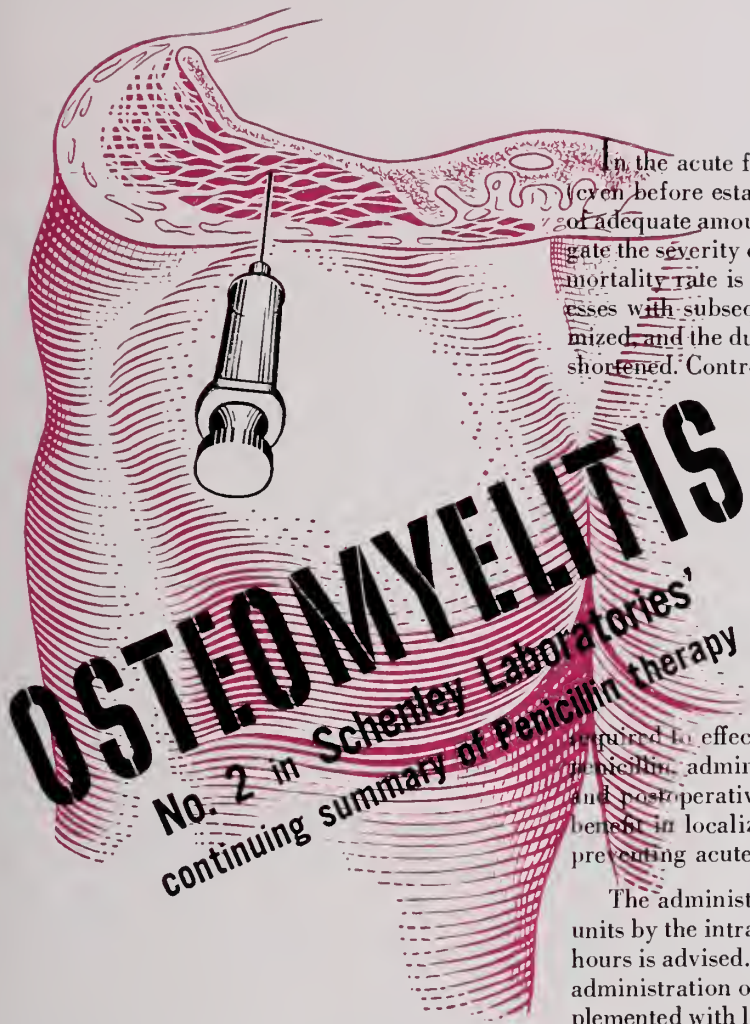
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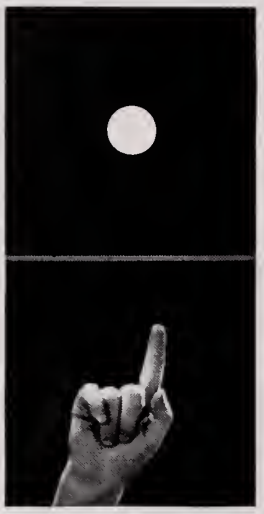
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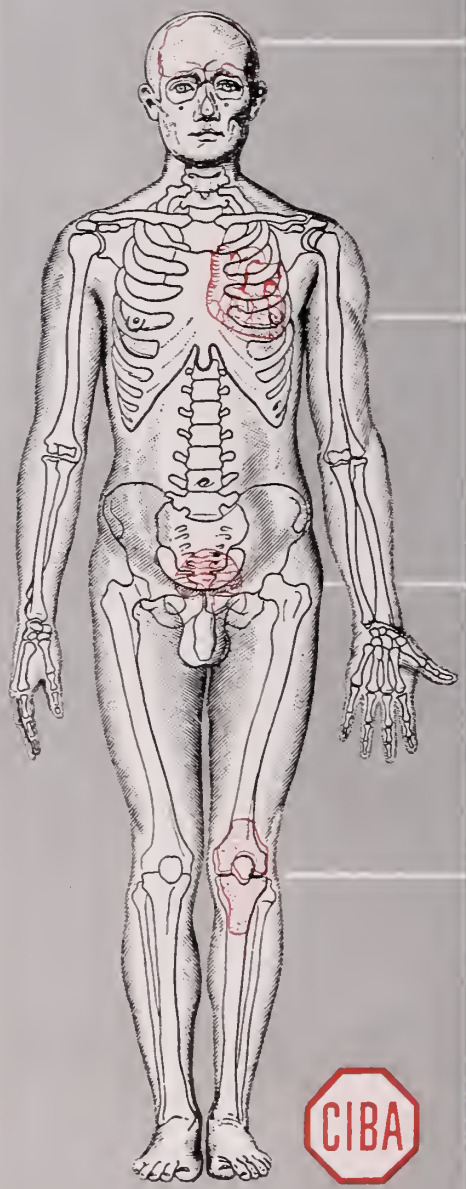
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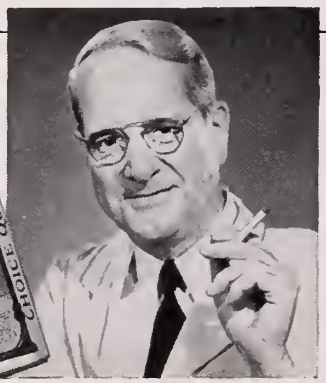


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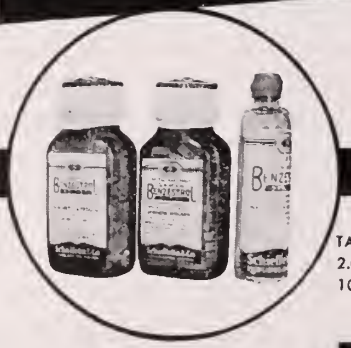
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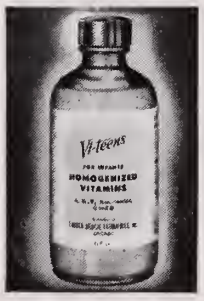
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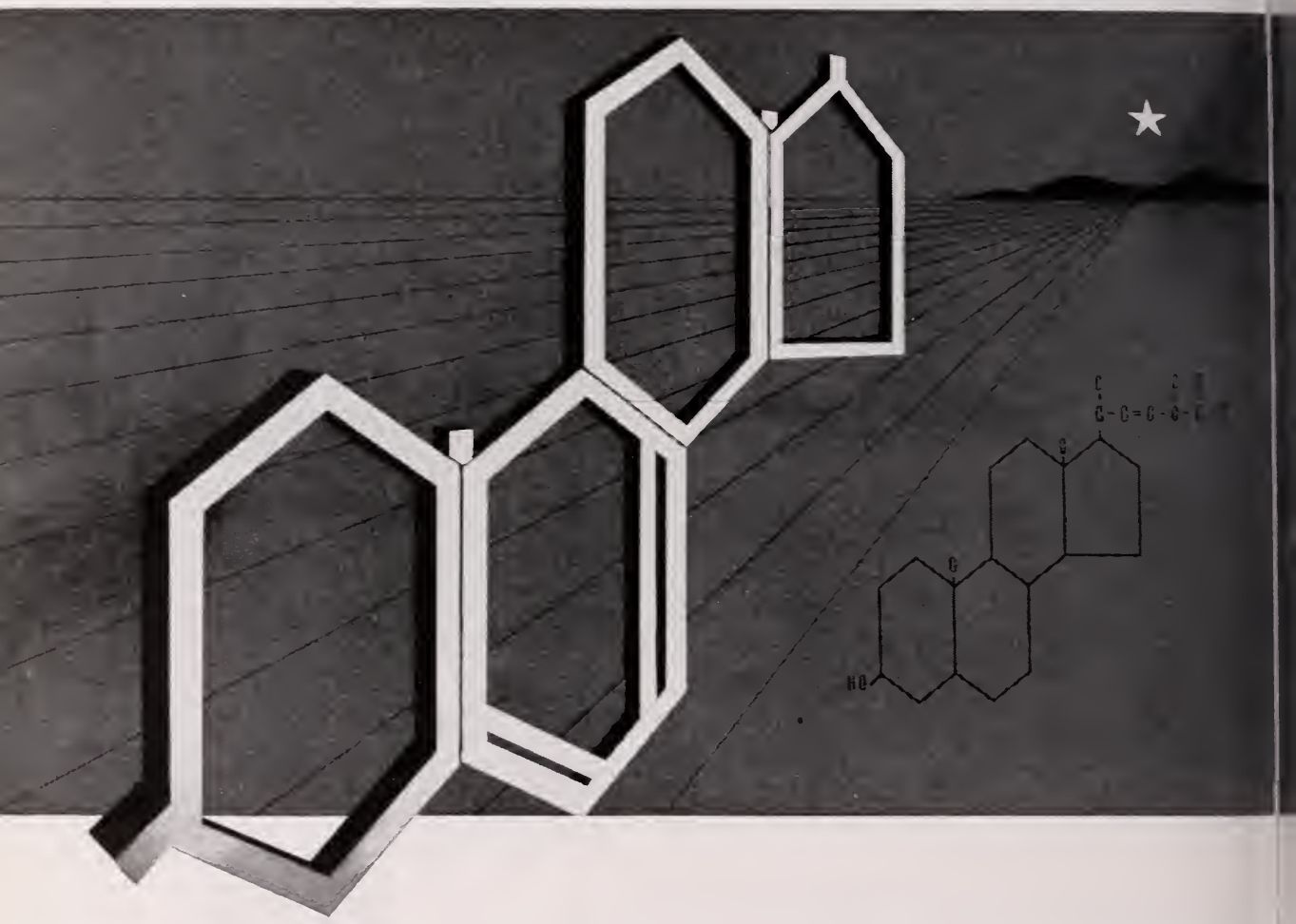
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VOL. XXIX AUGUST, 1946 No. 8

SURGICAL MANAGEMENT OF CARCINOMA OF THE COLON AND RECTUM*

THOMAS E. JONES, M.D.

The Author. *Thomas E. Jones, M.D., of Cleveland, Ohio. Surgeon, Cleveland Clinic.*

ACTIVE interest in the surgical management of malignancy of the colon and rectum of the past twenty years is evidenced by the large number of contributions to the literature. Anatomy, of course, has not changed, surgeons have not suddenly become expert, but improvement in surgical technic and the application of physiologic principles have increased the scope of operability, lowered the mortality, decreased morbidity, and increased curability. Allied branches of medicine such as x-ray have contributed materially to the earlier recognition of malignancy, and the renewed interest of pathologists has led to a better understanding of its spread; this knowledge has been very helpful to the surgeon in his surgical approach.

Early diagnosis, insistence on good preoperative preparation, improved anesthesia, and chemotherapy have all contributed to making the problem a much more hopeful one than formerly. From descriptions of operations performed, radical procedures seem to be the vogue, and curbed by the necessity of saving one kidney, a part of the stomach, or a part of the bladder, from an anatomical standpoint the surgeon has almost reached the limit in the eradication of malignant disease of the colon and rectum. Further benefits must come from earlier diagnosis, which obviously is lagging far behind improvement in surgical technic.

Therefore, even though this paper deals with the surgical aspect, I would be remiss if I did not emphasize again the importance of early diagnosis. I feel so strongly about it that I think it would be better for the next five years for surgeons to stop talking about surgical technic and compiling mortality and curability statistics in order to spend their time talking about early diagnosis. In the surgery he alone knows the tragedy of the late cases when he fits the condition at hand to a history that the patient had outstanding symptoms six months to a year ago. Many of these patients, we are sorry to say, did consult physicians.

The American Cancer Society and its program for cancer control was not originated by public health authorities, governmental agencies, or any professional group but has evolved from popular demand. Let us as a group not be delinquent. With an accurate history and thorough examination we can eradicate many of our trials and tribulations.

I have always been envious of the obstetrician. Around a birth the mother is happy, the father is happy, the doctor is happy (provided he has not lost too much sleep), and for once in her life, even the mother-in-law is happy. Contrast that with cancer of the rectum—when gloom pervades—yet I can visualize a brighter picture if we were a little more practical. For instance: (1) Everyone knows that 75 per cent of all cases of cancer of the colon are located where they can be felt with the finger or easily seen with the proctoscope; (2) the roentgenologist knows that the rectum is a blind spot for early diagnosis; (3) We all know that it is easier to order an x-ray of the colon than to think.

Now suppose that the roentgenologist had to have an affidavit to make or the moral courage to refuse to do a colon x-ray before a digital and proctoscopic examination had been done. Who would be happy? (1) The patient, because it was discovered early, easily, and without much expense; (2) the doctor, in taking just pride in his accomplishment; (3) the roentgenologist, because he didn't make a mistake or cause an impending obstruction by filling the colon with barium. A few rules among ourselves may avert rules made for us by people on the outside, and we know that a lot of people are trying to do just that.

From the standpoint of surgical technic there are admittedly many different ways of accomplishing a certain operation in a certain segment of

continued on next page

* Presented at the 135th Annual Meeting of the Rhode Island Medical Society at Providence, May 15, 1946.

the colon. The one fundamental prerequisite, however, is to do as extensive and as radical an operation as possible. Whether this is done by the closed or open method, by the one-stage or two-stage method, or by any other technic makes little difference provided the surgeon can show his results from the standpoint of mortality and morbidity are equal to those of other technics. Perfecting one technic is better than trying every new procedure that is introduced unless one has an abundance of material.

While one may prefer a certain standard procedure in certain segments of the colon, the findings at operation may necessitate a variation in technic. Obstruction, subacute perforation, or fixation must alter the course of even the staunchest advocate of the one-stage procedure. Graded procedures are necessary for utmost safety in this limited group of cases. In the final analysis the main controversy in surgery of the colon revolves around (1) the one-stage or two-stage procedure and (2) the open and aseptic or closed method of anastomosis. Improvements along one line or another may cause a change of method. For instance, sulfonamide therapy may change a two-stage operator into a one-stage advocate, or the use of the Rankin clamp may cause an advocate of the open method to use the closed method. However, I think less depends on the method used than the manner of its execution. A cursory review of mortality figures in recent years shows a disparity of 10 to 25 per cent for the same operation. This disparity is probably due to the manner of execution. I have always believed that peritonitis depends not so much on soiling as on leakage at the suture line or secondary to a bad wound infection. Since this can happen in the two-stage anastomatic procedure as well as the one-stage, I prefer the one-stage procedure.

In all statistics a higher mortality is quoted for palliative anastomosis and resection than for completed cases. This probably demonstrates the importance of vitamin and plasma protein deficiency in infection and wound healing. The patient with advance malignancy is probably lacking in both of these essentials and therefore cannot tolerate a minor procedure. However, cancer is a fatal disease and operative mortality cannot be viewed in the same light as non-fatal cases. The surgeon must be courageous. His responsibility is to palliate as well as to try to cure. The decision in any individual case rests upon the surgeon's experience, his philosophy regarding malignant disease, the patient, and the lesion.

Lesions in the right colon, whether in the cecum, ascending colon, or hepatic flexure, are best treated by right colectomy, with side open anastomosis. I believe the postoperative morbidity is less than in the group of end to side anastomosis over the Rankin clamp, as I formerly used to do. My preference in this group of cases is the one-stage right colectomy.

Formerly a small catheter was inserted by Witzel's method into the ileum about six or eight inches from the anastomosis to prevent tension on the suture line and to relieve pressure within the bowel. Lately this technic has been changed and the Miller-Abbott tube has been substituted with satisfactory results.

The great advantage of the one-stage over the two-stage procedure is economy in hospitalization and rehabilitation time, yet economy in time cannot be argued against safety. In either case these patients must have a few days of preoperative care in which transfusion is of first importance because so many have a secondary anemia. One of the greatest difficulties in resection of the right colon, particularly in the very obese patient, is peritonealization of the right gutter. Improperly completed, it will lead to adhesions and obstruction which is a definite factor in mortality.

For several years we have obviated this by use of the modified Mikulicz pack described recently. It prevents the small intestine from becoming adherent, and the postoperative convalescence is therefore much smoother. The combination of a well-prepared patient, decompression of the ileum either by Miller-Abbott tube or ileostomy tube, the use of the Mikulicz pack when indicated, the use of steel wire figure-of-eight sutures to prevent infection and disruption will, I feel confident, reduce the mortality considerably in this current series.

I have had no experience with the modified Mikulicz operation on the right colon. It has been advocated by Lahey in recent articles. Cattell reports a mortality of 3 per cent by this method in over a hundred cases. The objections to it, of course, are the same as for ileostomy in addition to the longer period of hospitalization. However, the discomfort does not last for many weeks, and if it lowers the mortality over the other operations by another 10 per cent it will become the method of choice.

The classical two-stage procedure is the side-to-side anastomosis between the ileum and transverse colon and the resection of the right colon at a later date. The objections are that (1) a person is running the risk of accidental death twice instead of once; (2) the hospital stay is greatly increased; (3) complications such as pneumonia, embolism, phlebitis, infected wounds, and so forth may delay or actually defer indefinitely the completion of the second stage procedure. Therefore, I use it only in cases where there is obstruction or perforation of the growth.

In the transverse colon one has a variety of satisfactory procedures. Ordinarily, mobilization is easy, and the blood supply is good. Mayo and Simpson report a mortality of 11.1 per cent in resection and primary anastomosis in contrast to 20 per cent mortality in 95 cases of extraperitoneal resection. Stone reports a mortality of 7.1 per cent in 14 cases by this procedure. In the past it has also been my choice. In my own 20 cases there were two deaths, a mortality of 10 per cent. In the one-stage procedure with resection, done in the manner of choice to fit the case, I believe it is important to do a complementary tube cecostomy. This is simple to do through a McBurney incision. It will lower mortality and morbidity, and does not prolong hospital stay, for if the tube is removed on the fifth or sixth day it will be closed by the time the patient is discharged from the hospital. In cases of marked obstruction, which generally is not the rule, the tube cecostomy should be done first under local anesthesia, followed in a week by resection. I thought my own mortality rate could be improved upon, and for that reason I am trying a series of Rankin obstructive resections. I have reason to believe that the mortality will be considerably lower, although sufficient cases have not been done for comparison.

If the obstructive resection technic is employed it is better to make the incision through the rectus muscle, right to left, according to the location of the lesion. The application of the spur clamp is safer, and in the closure of the stoma a better abdominal wall will result with less danger of weakness or definite hernia.

A lesion at the splenic flexure presents more difficulty than in any other segment of the colon. It generally lies very high and is frequently adherent to the spleen. In its mobilization the capsule of the spleen will often tear and give rise to very troublesome bleeding. In two of our cases the spleen had to be removed before operation could be proceeded with. In another case a gauze pack had to be placed tightly against it. I believe the obstructive resection is the best procedure here, and a left costal border incision makes it easier than a left rectus incision.

Prior to 1938 I favored resection of the sigmoid in the one-stage procedure with end to end anastomosis and frequently with tube colostomy above the growth or tube cecostomy, the present day so-called primary anastomosis. The mortality in this group, including descending colon and sigmoid in 128 cases, was 14 per cent. Even though it compared favorably with other statistics, I felt it could be improved upon. I had objected to the Mikulicz type of resection on account of the frequent postoperative hernias, and I had seen many cases of recurrence in the scar, the cause of which was obvious.

It seemed to me that the quoted mortality in this operation was too high, also, if it was designed to do away with the most frequent cause of death, viz., peritonitis from the open operation. Consequently, I started a series of the Rankin modification of Mikulicz's procedure. It seemed to me that one could do a more radical operation with this method than with the resection and anastomosis, a thing that the Mikulicz operation did not stress and the thing which caused the local recurrence. From January, 1940, to July, 1944, the series totalled 117 cases, 61 being in the left colon. The mortality was 6 cases or 5 per cent. This definite drop in mortality seems to justify continuance of the procedure in preference to others. In this group spontaneous closure of colostomy occurred in 11 cases or 14 per cent. The total hospital stay in this entire group of cases averaged twenty-eight days. This included preoperative treatment in all cases, in 10 of which a cecostomy had to be performed for obstruction, and the hospital stay for closure of the colostomy, the latter averaging eight days. It was not necessary to do a second operation for closure in a single case.

In the literature there is no apparent unanimity of opinion as to what constitutes the rectosigmoid. I take it to be the junction between the rectum and the sigmoid, and if the rectum is 5 inches long then the rectosigmoid should be a small segment of bowel beginning at about the peritoneal reflection and extending proximally for not more than 2 inches. Most lesions at this point obviously cannot be exteriorized, yet one frequently reads about the Mikulicz operation for rectosigmoidal cancer. As a working basis I consider a lesion whose lower edge borders on the peritoneal reflection, or a segment 2 inches above it, as rectosigmoid and subject it to the same operation as those listed under carcinoma of the rectum. Lesions higher than this are termed sigmoid. Elimination of colostomy has been a dream since time immemorial.

Dixon has been advocating resection and end to end suture on lower lesions, even bordering on or below the peritoneal reflection after a colostomy has been done in preparation. Babcock has been advocating a proctosigmoidectomy, the primary purpose being to have a perineal anus with some attempt at muscular control. Time only will tell whether the mortality, morbidity, and curability justify the procedure. In the past it certainly has been untenable.

My views upon the choice of surgical procedure for cancer of the rectum have long been known. As I first believed with firm conviction, even though with temerity, I am now more than ever convinced that the procedure of choice for this lesion and

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GASTRITIS AMONG NAVY PERSONNEL*

Russell S. Bray, M.D.**

The Author. *Russell S. Bray, M.D., of Providence. Captain, USNR Medical Corps; Senior Medical Officer of Gastro-intestinal Service, USN Hospital, Newport; Chief of Gastrointestinal Service, USN Hospital, Bethesda, Md.; Assisting Visiting Physician and Gastroenterologist, Rhode Island Hospital.*

The experienced clinician no longer doubts the existence of gastritis, and has accepted it as an important disease entity. However, there is still much to be learned about the abnormal gastric mucosa. Much of the confusion which envelops the subject might be clarified if it were possible to obtain an accurate correlation of clinical facts, laboratory, gastroscopic and pathologic findings.

During the late war, information of real value might have been obtained if it had been possible to carry out an accurate statistical and factual analysis of gastritis occurring among military personnel.

Certainly, many of the suspected etiologic factors; such as, fatigue, infections, food intolerance, thermal insults to the gastric mucosa, emotional and nervous trauma existed in great abundance.

In the Naval Service the medical officer, afloat or ashore, commonly attributed the multiple, unrelated complaints of the chronic gastric invalid to Gastritis. The faulty, but often appropriate, use of the term accounted for the high percentage rate of hospital admissions having the diagnosis of D. U. (Gastritis.)

This report is concerned with the known clinical facts, laboratory and gastroscopic findings in one hundred Naval Personnel hospitalized with the diagnosis of D.U. (Gastritis.)

Unless one is familiar with the peculiarities of naval medicine the term D.U. is meaningless. The Medical Department clings to the belief that the term is of value, but there are many of us who remain unconvinced. The term D.U., however, means "diagnosis undetermined." Actually it is a parenthetical diagnosis and the letters D.U. are followed by parenthesis within which is recorded the disease suspected or thought suitable for the occasion. Thus, a medical officer who labelled a patient D.U. (Gastritis) simply implied that he wasn't certain of the diagnosis but was betting on gastritis! Regulations required that an undetermined diagnosis be eventually changed to an established one. The acceptable diagnosis were listed in the Table of nomenclature.

The accuracy of the established diagnosis would depend upon the existing facilities for differential study or upon the scientific conscience of the medical officer. Due to the scarcity of experienced gastroscopists, the patient with D.U. (Gastritis) became an established case of gastritis chiefly by clinical inference.

The problem is further complicated by factors peculiar to the Naval Service. The organization of the Medical Department is a very fluid one. The prolonged close association of doctor and patient rarely occurs as both Medical officers and patients are constantly shifted from one activity to another. This shuffling about of doctors, patients and clinical records did not afford the Medical officer an opportunity to carry out a detailed study of group cases. The usual health record would contain numerous clinical impressions and changes of diagnosis, and would more often be confusing than helpful. Thus, any discrepancy between the facts and impersonal statistics may be readily understood.

The chief complaints or additional subjective symptoms which suggested the presence of Gastritis in the group studied, were as follows—of *32 patients* having proven Gastritis there were 21 who complained of vomiting, 30 of continuous epigastric distress, 11 of severe pyrosis, 14 of excessive flatulence, 11 of hematemesis, and 13 couldn't tolerate the usual Navy diet.

Of 68 patients *without Gastritis,* there were 35 who complained of nausea, 45 of epigastric or mid abdominal distress, 36 of vomiting—usually occuring during or shortly after a meal and often before the morning meal—15 of pyrosis, 23 of distressing flatulence (designated by their shipmates as "ward belchers") and 28 couldn't tolerate or bear the sight of Navy food. Hematemesis of undetermined origin had occurred in 3 of this group.

Gastric Analysis revealed among the gastritic group, a hyperchlorhydria in 12, normal free acid values in 18, and hypochlorhydria in 2. In the

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** Co-authors—Lt. Comdr. A. Hayles, MC, USN, and Lt. Comdr. N. Kemp, MC, USN.

group without Gastritis there were 25 showing hyperchlorhydria, 40 having a normal free acid range and hypochlorhydria was present in 2.

Barium progress studies were essentially normal. Unsuspected ulcer duodenum was demonstrated in two cases, but the usual finding was that of pylorospasm, gastric hypertonus and the irritable colon syndrome.

The gastroscopic picture was consistent with atrophic hemorrhagic gastritis in 9 cases, hypertrophic hemorrhagic gastritis in 2, simple atrophy in 15 and simple hypertrophic changes in 6.

The average patient age was 19 years. In as much as the group consisted of Naval, Coast Guard, Marine and Construction Battalion personnel the actual patient age varied greatly. All members of the group had served from 6 to 20 months in the South West Pacific and many had taken part in combat with the enemy.

The group as a whole presented the appearance and objective findings common to personnel who had spent many months in the Tropics—they were physically and mentally tired, weary of war, had lost weight, and the "jumpy" nerves of combat or occupational fatigue was apparent. The usual laboratory findings were secondary anemia and multiple intestinal parasites.

Although the incidence of individual symptoms have been enumerated, the percentage occurrence of any one symptom, with the exception of hematemesis, does not appear to have any actual clinical significance. It was the rule for patients to complain of multiple symptoms, the most frequent combination being, nausea, "heart burn", epigastric distress, flatulence and vomiting. Subjective symptoms did not follow any particular or specific pattern.

It has long been known that erosions and superficial ulcerations of the gastric mucosa occasionally produce hemorrhage. Blood occurred in the vomities of 11 or 32% of the patients having Gastritis. In no instance was bleeding profuse or fatal. Patients usually stated that they noticed the presence of blood during a bout of retching. However, an appreciable volume of fresh blood was found in the fasting secretion of five of the patients with Gastritis.

The gastroscopic picture of the 9 patients classified as atrophic hemorrhagic gastritis was interesting and perhaps unusual. There were patchy areas in which the color of the mucosa was a dirty greyish white or purple, with submucosal vessels well defined. The bleeding areas consisted of one or more small, circumscribed lesions, about the size of a dime and presenting a peculiar but striking "moth eaten" or slough-like appearance. They were most frequently seen high in the stomach below the cardiac shelf and usually involved the posterior wall. It was a common experience to discover small drops of blood oozing from the necrotic central area.

Although the general process was one of atrophy, the bleeding lesions were not consistent with the appearance of simple mucosal erosions, hemorrhagic submucosal flares or ulcerations.

We have seen similar lesions in 2 patients who were hospitalized for profuse hematemesis following an underwater blast injury to the abdomen. Both patients had been blown into the water and again literally blown out of the water by an underwater explosion. Gastroscopy demonstrated the presence of freely bleeding, spongy, moth eaten circumscribed patches similar to those already described.

Therefore it has occurred to us that the hemorrhagic lesions found in our cases may actually have been produced by trauma. More than half of the Gastritis patients were chronic "retchers". It was common for them to vomit their partly digested meal while enroute from the mess hall to the wards. The possibility of traumatizing an already damaged mucosa by the mechanics involved in retching or vomiting does not seem illogical.

Contrary to the usual finding, atrophic gastritis occurred in more than half of our cases. The reason for this is not known. The exact nature of gastric atrophy is still an unsettled problem. There may be different forms of atrophy; in some instances it may represent the end stage of an inflammatory process and constitute a true Gastritis, while in other cases it may represent a nutritional atrophy resulting from a constitutional disorder or deficiency state.

In our experience dietary and constitutional factors were, at least, important contributing factors. The importance of psychosomatic influences on gastric function has again been demonstrated by the painstaking observations of Wolf and Wolff.[1] By means of a gastric fistula they were able to observe the changes in color and vascularity of the mucosa, and appearance of the rugae induced by varying emotional stimuli. Schindler and Murphy[2] also mention the frequency of constitutional symptoms among patients having atrophic gastritis. In a thorough review of the general subject of Gastritis Bockus[3] states that clinical and laboratory evidences of Gastritis may be found in the absence of symptoms and that the appraisal of complaints in Gastritis is extremely difficult at all times.

As the result of our own experience we believe that it would be difficult to deny the importance of fear and fatigue as contributing etiologic factors in the patients we have studied. Some degree of hypochronic anemia was invariably present. However, an anacidity or depressed gastric secretion

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was an uncommon finding. The diet of Naval personnel in the South West Pacific was no doubt adequate from the nutritional standpoint but the tired and sensitive stomach of the war weary individual simply rebelled against the monotony of careless preparation, of spam, rice, beans, egg powder, dehydrated potato, and "butterless butter".

The treatment of these patients consisted of bed rest, sedative-antispasmodic remedies; whenever possible a bland diet, parenteral and oral vitamins, iron, eradication of intestinal parasites, and mental hygiene. The persistent "retchers" were ward fed but even supervision was not always successful, and the intractable patients would continue to lose their meals. It soon became apparent that the abnormal gastric membrane was only a part of a constitutionally sick individual, and whenever time and facilities permitted, psychiatric consultation and treatment was requested. In 7 of the patients with atrophy the mucosa regained a normal appearance. The remaining 25 patients were considered unfit for further duty and were transferred back to the United States. However, we were not convinced that their damaged gastric mucosa was responsible for their prolonged disability. Of the non-gastritis group 30 were returned to duty, but the profound emotional and functional disturbance of the remaining 25 required further hospitalization in the United States. Later studies showed that 57 of the entire group were eventually separated from the Naval Service.

The disposition of the sick is of paramount importance in the Naval Service. A man not capable of performing the duties of his rate is often a liability to the ship and of little value to a shore command. The frequency with which Gastritis was found among our 100 patients would imply a rather high rate of Gastritis occurring among those patients termed "chronic gastric invalids". However, the fact remains that the majority of such individuals suffer from functional disturbances, rather than organic disease. We believe it is extremely difficult to properly evaluate symptoms versus gastroscopic findings. Nor do we feel certain that a gastric mucosa damaged by emotional, nutritional or other agents is the sole cause of a prolonged disability.

The problem is particularly difficult in wartime, because the physician dealing with combat personnel must not only endeavor to appraise the existing disease, but must also consider the individual's ability and willingness to return to duty. When the evidence of gastritis no longer exists but subjective complaints persist, the ability of the individual to perform further useful service is in doubt.

Perhaps, with sufficient planning and foresight, it would have been possible for personnel with gastritis, functional disturbance of the gastrointestinal tract, and chronic peptic ulcer to have performed valuable service. But inasmuch as that utopia of organization was never attained, most of these unfortunate individuals would have served their country best—at home.

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SURGICAL MANAGEMENT OF CARCINOMA OF THE RECTUM

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those in the rectosigmoid, as I interpret it, is the one-stage abdominoperineal resection, the Miles operation. It offers the best hope of cure, the lowest mortality and morbidity, and the greatest palliation of all procedures. In a series of cases, the mortality is 7.2 per cent. From October, 1941, until June, 1943, we completed 137 consecutive cases without a single fatality.

It must be apparent from this number that bad risks were given a chance as well as good risks. The patient in 8 cases had liver involvement at the time of operation. Twenty-five had arteriosclerotic heart disease with hypertension; 5 had coronary heart disease; 4 had diabetes. Twenty-seven had had previous abdominal operation, which, in general, is a complicating factor. The total hospital stay in this entire group averaged twenty-two and one-half days and is now fifteen days. There were no disruptions and only three abdominal wounds were infected. Attention has been called to this before and has been attributed to the figure-of-eight alloy steel wire closure. Elimination of infection reduces mortality and morbidity to a very low percentage, which in turn increases the scope of operability. To include those with metastatic lesions will, of course, decrease the curability rate. That makes little difference. We will make more people comfortable for a longer period of time.

PROVIDENCE MEDICAL ASSOCIATION

Next Regular Meeting

MONDAY, OCTOBER 7

THE CONSERVATION OF PULMONARY FUNCTION IN THE TREATMENT OF CHEST CASUALTIES*

DAVID B. JENNISON, M.D.

The Author. *David B. Jennison, M.D., of Boston. Chief Resident in Surgery, Massachusetts Memorial Hospital. Formerly with the Army Medical Corps.*

THE treatment of chest casualties may be conveniently divided into two phases. The profound physiologic disturbances that occur following the injury urgently demand early consideration. After this phase many casualties demand further care because of retained foreign bodies, a persistent hemothorax or an empyema, any one of which may seriously compromise pulmonary function. It is this second phase that will be considered in this paper. The opinions expressed are largely the product of experiences gained at the Thoracic Center in the Central Pacific.

The general principles of the early emergency treatment of chest wounds may be summarized as early and adequate control of hemorrhage and shock; the closure of any sucking wound by an occlusive dressing or by debridment and suture; early treatment of tension pneumothorax; and early and complete aspiration of any hemothorax and/or pneumothorax. An elaboration of these principles does not fall within the scope of this discussion.

Pulmonary function is seriously disturbed following most intrathoracic wounds. Attention has long been focused on the treatment of the chest wound and any resultant pleural space complications. One of the outstanding developments in this last war has been a shift in the objective of treatment to the lung and the conservation of its function.

The sequelae of the inadequately treated hemothorax are the chief causes for the embarrassment of pulmonary function following chest wounds. These sequelae are clotted hemothorax and empyema.

It is now generally agreed that the best treatment of the acute traumatic hemothorax is early aspiration of all the blood that can be obtained. Specifically this means aspiration, within 48 hours of injury, of any chest which has an appreciable amount of hemothorax. Aspiration should be repeated at intervals of 24 to 48 hours until the pleural cavity is dry, or more frequently if needed to relieve respiratory distress. It has been suggested that the hemothorax should not be aspirated early due to the danger of reactivating bleeding but the experience during this war has failed to confirm these fears. The replacement of aspirated blood with air to control hemorrhage is also condemned. It is not necessary for controlling hemorrhage and if an infection develops the result will be a total instead of a basal empyema, due to the induced pneumothorax. If hemorrhage continues, it is usually from the chest wall and rarely from the lung. In either case, a limited thorocotomy may be required to control it. The objective in these cases is the early restoration of pulmonary function, by aspirating all blood or air, thus completely re-expanding the lung. The majority of hemothoraces will respond well to this treatment with very little residual deformity.

If the hemothorax is not completely aspirated an unpredictable amount of it may be naturally absorbed over a period of several weeks. It is not sound practice to depend upon absorption for there are a considerable number of cases (about 10%) in whom the hemothorax "clots". This clotting may begin as early as a few days after the injury by the deposition of fibrin on the pleural surfaces. Within a few days this fibrin is invaded by fibroblasts and arterioles from the pleura. After a few weeks, a dense inelastic membrane results which holds the lung in a state of partial collapse. The degree of the collapse depends upon the amount of hemothorax (and pneumothorax) present at the time the membrane became thick and inelastic. Eventually the clotted hemothorax becomes organized which leaves the casualty with a markedly deformed, so-called "frozen chest". Unless treated, this situation will persist for life, leaving a definitely diminished vital capacity and a deformity of the thoracic cage.

At the same time that the fibrous membrane is being formed over the pleural surfaces the remainder of the hemothorax frequently clots and becomes loculated making aspiration much more difficult. However, aspiration should always be attempted until it is obvious that it will not restore the lung to a position of essentially normal func-

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tion. In aspirating this type of hemothorax it should be remembered that fibrin settles to the bottom of the fluid. When difficulty is encountered in aspirating, the needle should be inserted one or two interspaces higher and frequently large amounts of fluid may then be withdrawn. Some of the "jelly-like" clots may be aspirated through large bore needles, such as a 15 gauge needle. Even though aspiration be successful, the inelastic membrane over the visceral pleura retards and may prevent the reexpansion of the lung.

During the period that the hemothorax is being aspirated the patient should do specific remedial breathing exercises which teach him to control voluntarily the unilateral and segmental respiratory activity of the poorly functioning region of his thorax. The importance of this has been stressed by Harken.

If definite improvement in expansion of the lung and mobility of the diaphragm and chest wall is noted then aspiration and breathing exercises should be continued until the chest is dry and function is restored. However, those casualties that have large clotted hemothoraces with fluid that cannot be successfully aspirated or lungs that will not expand following two or three weeks of aspiration, are best treated by thoracotomy, the manual removal of the clotted hemothorax and, if necessary, decortication.

Decortication was first used by Fowler in 1893 for chronic suppurative disease. This very valuable procedure has enjoyed a somewhat limited use until recent years due to the need for improved methods of anesthesia, blood transfusion and bacteriostatic agents. In this last war, the potentialities of decortication have been realized and used in all theatres.

Decortication is the removal of the thick constricting capsule of organizing fibrin which forms over the surface of the lung, thus permitting its reexpansion. The procedure is accomplished by using the typical postero-lateral incision and resecting a portion of the sixth or seventh rib. The periosteal bed is incised and the pleural cavity entered. All fluid and the jelly-like clots of the organizing hemothorax are removed. An attempt may then be made to expand the collapsed lung by means of positive pressure (about 8 to 10 cm. of water) from the anesthesia machine. If this is unsuccessful because of the constricting fibrin capsule over the surface of the lung a decortication is done.

Usually over the lateral portion of the lower lobe a point is selected to enter the fibrin capsule. Blunt dissection is used and a line of cleavage is established between the fibrin capsule and the visceral pleura. As soon as this is accomplished the fibrin capsule is grasped with a forceps and the visceral pleura is then wiped away from it with relative ease. This procedure is used to free the entire surface of the lung, except in those areas where there has been trauma causing scar tissue or in those cases where the organized fibrin has been allowed to remain so long that it has become too firmly adherent to some portions of the pleura. The underlying pleura is smooth and almost normal in appearance. The organized fibrin is stripped away from the costo-phrenic angle and the diaphragm. The lung is completely freed from the thoracic wall and mediastinum and the lobes of the lung are separated from each other if not too firmly adherent. No attempt is made to remove the organized fibrin from the parietal pleura since the procedure is accompanied by greater technical difficulties and more bloody oozing than is warranted by the small increased benefit derived. At the end of the procedure the pleural cavity is irrigated with saline to wash out all blood clots and to detect the presence of any broncho-pleural fistula that should be closed. A drainage catheter is inserted through a stab wound. The lung is completely inflated and the wound closed in layers. Encircling pericostal or perichondral sutures should not be used. Following closure all air is aspirated through the chest catheter to insure maximum reexpansion of the lung.

Post-operatively penicillin is given routinely. Breathing exercises are initiated as soon as the patient is able to execute them. The drainage catheter in the chest may be placed in a water seal drainage bottle or on controlled suction (10 to 15 cm of water) and removed when it ceases to function. Following removal of the drainage catheter a small accumulation of sero-sanguinous fluid frequently occurs. This will usually become absorbed. If there is an appreciable amount it should be aspirated.

The optimum time for doing a decortication appears to be between the third and sixth weeks following injury. If done before the second or third weeks the fibrin capsule over the lung is friable and hard to remove. If done after the tenth to fourteenth weeks it is tough and densely adherent to the pleura.

Experience with this procedure has indicated that in the majority of cases very satisfactory results are achieved. The patient is given a lung that has almost complete restoration of function.

A brief summary of a typical case and the results obtained will be of interest.

A 22 year old enlisted man received a penetrating .25 cal. bullet wound of his left chest on 7 April 1945. He was evacuated to a Field Hospital 9 hours later where he was given 2000 cc of blood and 500 cc of plasma. His wound was debrided and he was found to have two fractured ribs. On 12 April a thoracentesis was done aspirating 1000

cc of blood. Eight days after his injury he was evacuated to a Station Hospital in the Marianas where he was given 2000 cc of blood. Two more thoracenteses were done, 950 cc. of blood being aspirated on 23 April 1945 and 50 cc. of blood on 24 April 1945. He was evacuated to this General Hospital 8 June 1945. At that time he had a large clotted hemothorax that would not yield to aspiration. Accordingly on 13 June 1945 a thoracotomy and decortication was done. About 1000 cc. of thin brown fluid was removed along with several large jelly-like clots. A dense fibrin capsule which prevented expansion of the lung was also removed. The lung reexpanded well and the patient's postoperative course was uneventful. At the time of discharge 38 days later there was only slight dyspnea on moderate exertion and slight limitation of expansion of the left side of his chest on inspiration.

The development of infection in a hemothorax is a serious complication which demands prompt treatment. A common source of infection is direct extension of infection into the pleural cavity from an infected wound. This is seen particularly in those cases with large wounds requiring muscle flap closures. Contamination may be introduced by the metallic projectile, particularly large jagged fragments that lodge within the chest. Less common causes of infection are broncho-pleural fistulas and the carrying of abdominal contents into the chest in thoraco-abdominal wounds. Either aerobic or anaerobic organisms may cause the empyema.

The treatment of an infected hemothorax may be different from the post-pneumonic empyema for several reasons. There is usually a thick fibrin capsule covering the pleura which limits the ability of the lung to reexpand. The hemothorax when infected may clot and pocket which makes drainage difficult. If the hemothorax is large a total empyema is formed.

The post-traumatic empyemas are treated with the objective of obtaining early and complete reexpansion of the lung as soon as possible. Small empyemas arising from a clotted hemothorax, that are well localized and have an underlying lung that is not limited in its ability to fully expand, thus obliterating the cavity, may be treated by open drainage. This method is also excellent for the extremely sick patient with a massive empyema whose condition permits only simple non-shocking surgical procedures.

The treatment of empyemas by decortication is designed for those cases that have had a large clotted hemothorax, which has become infected, and in whom there is a layer of organizing fibrin on the surface of the lung which would prevent its expansion. Simple drainage of this sort of empyema would leave a large chronic empyema cavity that would at best require many months to become obliterated. Furthermore, the clotting that makes aspiration unsuccessful also is likely to interfere with proper drainage of the empyema. If the patient is in condition to stand the shock of a decortication, he will in most instances, have a fully expanded lung and the empyema will be cured within a short period of time.

Preliminary aspirations should be carried out with the instillation of penicillin into the pleural cavity temporarily sterilizing, if possible, the infected hemothorax. As soon as the patient has been adequately prepared, a thoracotomy is done, all pus and fibrin clots are removed and a decortication is done. In all cases a drainage catheter is placed through a stab wound and after the chest has been closed 50,000 units of penicillin are instilled through the catheter which is then left clamped for three hours. Otherwise the postoperative care is the same as that noted for decortication of the uninfected hemothorax. Occasionally small empyema pockets form following a decortication for empyema. These usually respond well to open drainage.

The dramatic results that can be achieved are illustrated by the following typical case.

On 13 April 1945 a 21 year old enlisted man received a severe high explosive wound of his right chest, entering at the base of the right side of his neck and lodging in his right lung. This produced a sucking wound which was closed four hours later by the application of a vaseline gauze pack at a Field Hospital. Two days following the injury he received a thoracentesis which was repeated approximately every second day for two weeks; a total of about 1900 cc. of blood being aspirated. He was admitted to this General Hospital 25 May 1945, 42 days following injury, with his right chest filled with purulent fluid. He received aspirations on 25 May 1945, obtaining 900 cc. of creamy pus; on 26 May obtaining 875 cc. of pus; and again on 28 May obtaining 600 cc. of pus. Staphylococcus aureus was grown on culture. Following each aspiration 50,000 units of penicillin were instilled. X-ray of his chest demonstrated a total collapse of his right lung which would not reexpand following aspiration. Therefore, a decortication was done 2 June 1945 and the metallic foreign body removed. A large amount of thick greenish pus and jelly-like clot was removed. The lung was almost totally collapsed and covered by a thick layer of dense organizing fibrin. Following decortication the lung reexpanded well. An inlying catheter was inserted and 50,000 units of penicillin were instilled. He received 25,000 units of penicillin intramuscularly every three hours post-operatively. This patient's course was excellent with rapid recovery. He had

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progressive and very satisfactory clearing of his lung field on the right as noted by serial x-rays. He was ready for discharge seven weeks later and could do all but strenuous duty. There was only a slight decrease in expansion on inspiration on the right and partial obliteration of the costo-phrenic angle.

Some infected hemothoraces do not have frank pus as illustrated by the following case. In this case the cause for the infection appeared to be a wound of entrance which was not successfully closed.

A 23 year old enlisted man received a severe penetrating high explosive wound of his left chest on 10 April 1945, which entered in the region of the 12th rib, approximately 6 cm. to the left of the midline. This produced a sucking wound which was not relieved until about six hours later at a Battalion Aid Station, where a tight adhesive dressing was applied and he was given one unit of plasma. He was then evacuated to a Field Hospital where the wounds were debrided and a vaseline gauze pack was placed over the chest wound. A laparotomy was done at the same time because of a suspected penetration of the diaphragm but this proved to be negative. Five days later he was evacuated to a General Hospital on Guam, where an x-ray showed a massive hemothorax. On 6 May 1945, 26 days following the injury, the first thoracentesis was done, obtaining 30 cc. of bloody fluid, and 11 days later a second thoracentesis was done, obtaining 500 cc. of bloody fluid. A chest plate at this time showed only slight improvement. On 24 May 1945 a delayed closure of the wound was attempted, but two days later this broke down due to spontaneous drainage of much fluid from the left pleural cavity. This drainage continued until the time of admission to this hospital on 6 June 1945, 57 days following injury. On admission he had a partial left hemothorax which was draining through the wound of entrance and a large metallic foreign body located in the left pleural cavity. Only small amounts of cloudy brownish fluid could be aspirated. Staphlococcus aureus was grown on culture. On 9 June 1945, almost 9 weeks following his injury, a thoracotomy, decortication and removal of the foreign body was done. The lung was about three-quarters collapsed. Much cloudy brownish fluid and jelly-like clots were removed. A thick fibrin capsule was dissected from the visceral pleura and a metallic foreign body measuring 2.8 by 1.3 by 1.0 cm. was removed. Technically the procedure was not particularly difficult and the lung expanded well following decortication. The sinus leading from the left pleural cavity through the wound of entrance was noted and admitted the tip of the small finger. This was closed with a suture. A drainage tube was inserted through a stab wound. The postoperative course was uncomplicated and he showed satisfactory progress in the clearing of his chest as demonstrated by x-ray. At the time of discharge 44 days following the operation he was able to do all but strenuous activity. The x-ray showed some thickening of the pleura and some obliteration of the costo-phrenic angle but otherwise the lung field was essentially clear.

A conservative attitude should guide one in deciding upon the removal of foreign bodies from the thoracic cavity. The operative risk and the probability of returning the casualty to duty should always be balanced with the complications which the foreign body may cause in the future, that is hemorrhage or suppurative disease of the lungs or pleural cavity. This is particularly true for overseas installations where in general elective surgery is not done for battle casualties. If a foreign body is to be removed, however, and its removal will allow the patient to return to duty and/or is not inconsistent with the evacuation policy of the theatre, then it is desirable to have the period of recovery from the operative procedure coincide with or overlap the period of convalescence for the injury.

Before considering removal one or more of the following criteria for removal should exist. Hemoptysis is a definite indication for the removal of a metallic foreign body, if other diseases such as bronchiectasis or tuberculosis can be ruled out. Another criterion is infection of the tissues about the foreign body as demonstrated by x-rays. Foreign bodies lying in empyema cavities, if obtainable without too much effort, should certainly be removed. It is hard to determine on the basis of size and shape of a foreign body, whether or not it should be removed, because of the fact that the location of these foreign bodies in relation to vital structures governs to a degree the harm that the foreign body may cause. However, in general, it is felt that a foreign body 1.5 cm. in diameter or larger should be removed. The more jagged the outline of the foreign body, the more likely it is to have carried in pieces of clothing and other foreign substances, thus establishing potentialities for infection. The symptoms of pain and cough are very difficult to evaluate. Unless the foreign body is at the periphery of the lung impinging on either the pleura or the diaphragm these symptoms are more frequently due to adhesions or nerve involvement in the chest wall than to pathology immediately surrounding the foreign body. Psychosomatic factors should eventually be considered but this criterion should be reserved for special evaluation in thoracic centers on the Mainland.

The foreign body should first be carefully localized by anterior-posterior and lateral x-rays. A fluoroscopy is most helpful in many cases. In cer-

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The RHODE ISLAND MEDICAL JOURNAL

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COMMUNITY LEADERSHIP

RECENTLY one of our "throw away" magazines had the story of a physician made president of a university. This seems unusual. Ray Lyman Wilbur is the only other one that comes immediately to mind though doubtless there are a few others. Even our medical schools are not headed by their own products since they are only appendages to academic organisms.

Not only are physicians seldom presidents but they seem to be conspicuous by their absence on boards of trustees or other governing bodies. A striking example near at home is afforded by Brown University. Soon after the Civil War Dr. W. W. Keen was made a trustee and later a fellow. The whole-hearted, enthusiastic and skilled service that he gave for many years might have suggested that more of his breed be used. But we believe that never since has a medical man been a Solon at the college on the hill. It would be easy for us to make a list of physicians, loyal Brown graduates, who would have brought much needed attributes.

Possibly the first source from which the boards have been filled has been successful business men. Shrewd traders, hard drivers, but not at all necessarily repositories of educational wisdom. And the lawyers who are notoriously the governing class are by the very nature of their work special pleaders. Imagine their considering each case on its merits and then insisting on working on the side where they felt truth lay! But this is exactly what good physicians are always doing. With every desire in the world to consider a case benign they will never cease in their efforts to show malignancy if it is there.

Such a customary viewpoint and such training should make medical men invaluable counselors. Why are they so seldom called upon? We believe it is explained largely by a remark of Sir William Osler, "Medicine is a jealous mistress. She will brook no rival!" Who would want to use a surgeon who had to pass half his year in legislative halls? One general practitioner was governor of Rhode Island, but still the conviction holds that the good physician must make that his life work.

Since writing the above, we have read the address at San Francisco of Dr. Roger Lee, President of the American Medical Association. It is pleasant to find that our weak gropings to express an idea have brought us somewhere near the conclusion which this clever man expresses so well. We conclude with an extract from his remarks.

"I believe he (the doctor) is entitled to a seat and a voice at the council table and not in the next

continued on next page

room as a possible expert or specialist. I believe the local community, the state, the nation and any congress of nations would benefit by his advice on public matters. Today he is almost automatically excluded, and thereby the world suffers. Furthermore for its own interests, which are so peculiarly altruistic, the medical profession needs a voice at the council table. No other group is more unselfish and altruistic in its traditions and aims than medical men. And yet in a recent unofficial and voluntary conference on world affairs no doctor of medicine was present in the throng of lawyers, clergymen, editors, social scientists, physical scientists, commentators and others.

"Why this exclusion from public and world affairs? I have suggested the trite and time worn explanation that the doctor is occupied and engrossed in purely professional matters. But certainly doctors have attained standing in poetry, music and the creative arts. They can hardly be accused of a constricted horizon. Somehow for the benefit of the general public and of the world and for the benefit of the medical profession itself this situation ought to be remedied."

ONE ORGANIZATION — THE AMA

No meeting of the House of Delegates of the American Medical Association in recent years has been marked with such agreement of purpose and unanimity of decision as that held recently at San Francisco. We are encouraged by this demonstration, and we hope we see in it clear-cut evidence of a concerted movement at last towards solidarity in the parent organization that will dispel the criticisms that have mitigated against the profession in general in the recent past.

The creation of a new public relations division with an executive director who will also be administrative assistant to Dr. George Lull, secretary and general manager of the Association, has been construed widely as a step to divorce Doctor Fishbein from his role of spokesman for the profession and to restrict him to his duties as editor of the JOURNAL and allied publications. But the action has a far greater significance as we view it.

It has been generally agreed that the medical profession has been put in a bad light by those who have fault to find with the distribution of medical care, and who have spared no efforts in their attempts to socialize medicine. Also, by its failure to tell its side of the story effectively and accurately, organized medicine has been kept on the defensive in the current debates that have culminated in the proposal of national legislation for compulsory health insurance.

At its meeting last December the House of Delegates authorized the Board of Trustees to engage the services of an outstanding public relations group to survey the framework of the AMA, and to advise it on how to improve its programs. The unbiased report of this public relations authority, submitted to the Trustees, and revealed in part to the House of Delegates last month, resulted in the action for a new division in public relations, and also in the re-organization of the Bureau of Medical Economics under the supervision of outstanding full-time economists.

However, what was not clarified was what is to be the relationship that is to exist with the National Physicians Committee and similar agencies that have established programs for the promotion of medical public relations, now that the AMA is to have its own division to carry on this work. The issue was sidestepped in the public discussions, although from reliable sources it was reported that the study submitted to the Trustees cited the necessity for the Association to divorce itself from such groups and to handle its own public relations activities.

We in Rhode Island have long maintained that the American Medical Association is the national organization that has our support. We are the one state in the country that has not been organized by the NPC. Not that we are opposed to what the NPC is trying to do, but rather that we feel the same work can be done better locally by our own society, and better on a national level by the AMA.

Two years ago we stated editorially on this question that "It has probably been the failure of the State medical societies to instruct properly their delegates, and the subsequent failure of the delegates clearly to enforce the viewpoint of the majority of the profession that has contributed to the misunderstandings and conflicts in opinions that have been rampant throughout the profession relative to the parent organization. The remedy is apparent, and it is not the creation of new associations."

The diagnosis has been made by the public relations authority employed by the Trustees. A remedy has been prescribed by the action of the House of Delegates. The patient will be studied constantly for improvement.

THE PROVIDENCE TUBERCULOSIS LEAGUE

The people of Providence, physicians and laymen alike, have every reason to take pride in the accomplishments of the Providence Tuberculosis League. It is outstanding among organizations of its kind in the United States. It is very fortunate that an organization of such importance has had the splendid leadership under Dr. Pinckney to instill the feeling of confidence and popularity that has been demonstrated by its record. During the year 1945, 19,405 x-rays were taken and innumer-

able chest examinations done by the shorthanded staff. The list of referring doctors reads much the same as the telephone directory of Physicians and Surgeons in Providence with the omission of those doing x-ray work exclusively and the addition of many names outside Providence. We doubt if any greater accomplishment has been achieved by any comparable organization. It may be taken as practically 100 per cent confidence by the doctors of the city.

It is most encouraging that such support is given by the doctors toward the cause of discovering Tuberculosis early, when it can be readily treated. That this has resulted in the discovery of many early cases is shown by the fact that almost 70 per cent of those who were found to have pulmonary tuberculosis were still in the minimal stage and only 14 per cent far advanced. Encouraging as this may be, there is a dark spot in the system. The question is what happens to these minimal cases after they are discovered? Certainly they do not all go to sanatoria or there would be a considerably higher percentage of minimal cases admitted than there are now. True, some are able to receive satisfactory treatment at home, but all too often they drift from under the eye of medical supervision into a moderately or far advanced stage and then too late awaken to the seriousness of the condition and swell the percentages of advanced disease filling our institutions, a wonderful opportunity lost. And it is a wonderful opportunity. What other chronic serious disease that commonly attacks young adults is curable in any stage? The Providence Tuberculosis League finds the disease, but it is up to the referring physician, the man who knows the patient to do all in his power to see that proper treatment is carried out. True, this may demand imploring, persuading, brow-beating, but what can be more worthwhile than saving a life from premature snuffing?

Not only does the Tuberculosis League receive patients referred by private physicians, but with its mobile unit it has done pioneer survey work in Providence. This unit travels to industrial plants and other places where large groups volunteer for or request chest x-rays for screening purposes. This should in the future be a universal procedure. The returns are high. During 1945, a little more than 90 per cent of the cases found by this means were in the minimal stage. The method is still looked upon with some suspicion and fear by certain groups representing the laborer and others representing management, but its value is proven and it is but a matter of time before routine x-raying will be as generally done as is vaccinating against serious infectious diseases. The longer it is delayed, the longer will tuberculosis be a plague on both your houses, labor and management. It is one of the foibles of human nature that it will demand tremendous outlays of money, time, equipment, personnel, sympathy to take care of disabling diseases, but won't ask an iota or lift a finger to help prevent these diseases. If a small fraction of these items that are spent or are contemplated being spent on treating incurable conditions were spent on prophylactic measures and early treatment, our government could worry about finding some other way to spend our money.

The Tuberculosis League is showing us the way, backed by the doctors of Providence, but we must double and redouble our efforts and our backing. It seems to us quite unique the popularity with which the lay public holds the League. It seems to have none of the onus that surrounds many other public and especially tuberculosis organizations. People visit and revisit this clinic and come out satisfied. This can only prove that they are handled with efficiency and respect. A model is set from which many clinics could take heed.

CEREBRAL PALSY

An article in a recent number of the JOURNAL presents a comprehensive description of recent advances in the understanding and treatment of children suffering from cerebral palsy. There is already widespread interest in this subject throughout the country and centers for providing the proper medical and educational facilities for such children are being established in a great many cities.

Rhode Island physicians are probably aware that this State at the present time lacks adequate facilities for handling this problem. From 1931 until 1942 a residential treatment unit for children with cerebral palsy was maintained at the Bradley Home but it was discontinued as the work of this hospital developed in other directions. It will doubtless interest the medical profession that some months ago an informal committee made up of representatives of various welfare agencies in the Providence area undertook to investigate the possibilities of improving local facilities. In February of this year the Health Division of the Providence Council of Social Agencies initiated a series of meetings and conferences to discuss the problem further and published in mimeographed form a survey covering the problem and lack of present Rhode Island facilities. In this report a statement from the Division of Crippled Children, Rhode Island State Department of Health, notes that 157 individuals with cerebral palsy were known to the Division on that date, almost all of these being individuals under 20 years of age. It is quite likely that the true number is much larger. At the present time the Council is accumulating information as to what may be done for such patients in Rhode Island in terms of what

continued on next page

is being done elsewhere. The Division of Crippled Children is conducting a new survey to register all such patients in the State so that the actual magnitude of our problem may be known. A tentative proposal has been made that an independent day-school project for a selected group of these children be established in the Providence area on a demonstration and research basis. The core of a treatment program must be physiotherapy, but medical study and treatment, academic education, social training, and the guidance of parents and families who must care for these handicapped children when they are not in school are important features which should be included.

The physicians of Rhode Island will be interested in this project not only because it will eventually furnish much better service for their patients with cerebral palsy, but also because it will reestablish within this State an up-to-date training center where much that is new and valuable may be learned and disseminated to all communities of this State and elsewhere. The interest already shown by a small group of physicians and a larger group representing the various welfare organizations is greatly to be commended and deserves the hearty backing of all readers of this JOURNAL.

7th ANNUAL INDUSTRIAL HEALTH CONGRESS

At a meeting held in San Francisco last month, at the time of the AMA sessions, representatives of the Council on Industrial Health, the U. S. Public Health Service, and the Council of the New England State Medical Societies furthered plans for the 7th annual Congress on Industrial Health to be held in Boston the week of September 30. Headquarters for the meeting will be at the Copley-Plaza hotel.

The plans now under way call for preliminary meetings of committees and council on September 28 and 29, with the Congress officially opening on Monday, the 30th, with the morning meeting given over to a symposium on lead poisoning. An all afternoon surgical conference will share honors with a discussion for interested groups on "The Foot in Industry." A state society dinner and conference will climax the first day's program.

Tuesday's meetings will be highlighted by a morning symposium on problems in industrial medicine from the viewpoints of labor, management, and medicine. Elective conferences are planned for the afternoon on industrial physiology, administrative methods, aviation medicine, and workmen's compensation. A Pan-American dinner and conference will be held in the evening.

On October 2, Wednesday, the morning symposium will highlight medicine and industry in a physico-chemical age, and the afternoon discussion will be given over to physical fitness program in industry, with the Bureau of Health Education of the AMA contributing some interesting data. A public dinner highlighting health and welfare leaders in industry will be held in the evening. On Thursday, October 3, a therapeutics conference will be conducted in co-operation with the AMA Council on Pharmacy and Chemistry.

The meeting in Boston this year will mark the first time that the Congress on Industrial Health has ever been held outside of the city of Chicago. Responsible in no small measure for bringing the Congress to New England, the most highly industrialized area in the world, has been the recently organized Council of the New England State Medical Societies composed of representatives from each of the state medical associations in this region.

FEDERAL SECURITY AGENCY
Washington

Procurement and Assignment Service

June 10, 1946

William P. Buffum, M.D., Secretary
Rhode Island Medical Society
122 Waterman Street
Providence, Rhode Island

Dear Dr. Buffum:

For practical purposes the functions of the Procurement and Assignment Service have been terminated and the activities of the several State offices brought to a close. The success of the program in meeting the needs of the armed forces without sacrificing the civilian population may be attributed directly to the patient and timeless devotion of many State Committees and countless local advisers. Many of these Committeemen and advisers are unknown to the Directing Board, except through the results of their efforts, and it would obviously not be practicable to undertake to communicate with them.

In a recent letter to each State Chairman, I asked that the appreciation of the Directing Board be conveyed to all the state and local representatives whose full cooperation was essential to the ultimate achievement. The Directing Board, at its final meeting on May 17, 1946, resolved that the untiring efforts, kind tolerance, and successful accomplishment of these State Committee members and local advisers be commended to the appropriate professional State Society for suitable recognition by the Society.

I hope that you will draw this recommendation to the attention of your Society, and that they will be disposed to afford some such recognition.

Sincerely yours,

(Signed) FRANK H. LAHEY, M.D.
Chairman, Directing Board

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

AMA HOUSE OF DELEGATES

Report of ALEX M. BURGESS, M.D., *R. I. Delegate*

THE 1946 meeting, held at San Francisco, July 1st to 5th, was well attended and successful. The work of the Local Committee on Arrangements, made up of members of the Medical Association of San Francisco is to be highly commended. Everything was done for the comfort and convenience of those attending the meetings despite the occurrence of the street-car strike which made the use of special buses necessary. The Scientific Session and the scientific and technical exhibits were of the greatest interest as far as your delegate was able to judge them at times when meetings of the House of Delegates and reference committees did not demand his presence.

The sessions of the House of Delegates were, as usual, characterized by intense activity with the usual large amount of work accomplished. Inasmuch as the details of the actions of the House are being published by the A. M. A. Journal this report will deal with a few highlights only that may be of particular interest to Rhode Island physicians.

As regards the resolution passed by the Rhode Island House of Delegates on May 8, 1946, dealing with the matter of certification of illness and recovery by attending physicians in carrying out compulsory cash sickness programs, it was introduced by your delegate, studied in detail by the Reference Committee on Legislation and Public Relations, reported favorably to the House and unanimously passed by that body. (See special report on page 609.)

A further interesting recommendation made by the same Reference Committee and also adopted by the House was to the effect that rather than attempting to make a national plan for voluntary prepayment insurance each state should develop its own plan independently and that a continued study of low income groups, particularly in farm areas, should be made. If subsidies should become necessary the plan of granting them at, or below, state levels was advised.

The Report of the Board of Trustees, which, as usual, gives evidence of intensive and detailed work throughout the year will repay study as it is published. One action on their part is, I believe, of especial interest in view of the widespread feeling on the part of a large group in the profession that the Editor of the Journal should be required to confine his work to his duties as Editor and not attempt to represent the Association on matters of medical economics or public relations. The Board of Trustees, apparently realizing the situation, reported that they had employed a firm of consultants who had made a detailed study, including a survey of all actions of the House of Delegates for the past six years, and many contacts with legislators, labor and farm groups and others throughout the country. These consultants expressed the opinion that the work of the American Medical Association, as far as publicity is concerned, should be divided into three fields each under the supervision of an expert. These divisions are (1) scientific, (2) medical economics and (3) public relations. As regards scientific work they recommended that the publication of this work be, as at present, the responsibility of the Editor of the Journal. They stated their belief that the same individual cannot adequately carry on this work and at the same time deal with medical economics and public relations. They therefore advised that a person of high calibre be obtained to promote the work of the Bureau of Medical Economics. They suggested that in this department an opportunity be given for a full expression of diverse viewpoints and minority opinions. Such a director, it was reported, has already been tentatively selected. In the matter of public relations the consultants believed that the attitude of the profession has, in the past, been too defensive and negativistic. They advised the further development of the positive program which has now been adopted. This, they believe, should include definite enlargement and improvement of the magazine Hygiea. They recommended that an expert be selected to head this work in public relations and that he be made an executive assistant to the secretary, Dr. Lull. The Board of Trustees has adopted the recommendations of the consultants with slight modifications only and this action was approved by the House of Delegates. This disposes of the question as to the proper publicity methods of the Association, including the activities of the Editor, to the satisfaction, it is believed, of all concerned.

In the election of officers all were chosen unanimously except the speaker. In honoring Dr. Olin

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THE BRADLEY HOME — A CHILDREN'S PSYCHIATRIC HOSPITAL

ON APRIL 8, 1946, when the Emma Pendleton Bradley Home completed its first fifteen years of service, it was still the only independent children's psychiatric hospital in the United States. This institution, located on the eastern shores of upper Narragansett Bay in the Riverside section of the Town of East Providence, is about five miles from the center of the City of Providence. Its origin dates back to an endowment provided in the wills of the late Mr. and Mrs. George L. Bradley of Providence, who many years ago decided to leave their entire estate to erect such an institution in the name of their only child. A Board of Trustees, made up of outstanding Rhode Island citizens, was selected in 1925 to administer this endowment and has directed the policies and financial support of the hospital during its construction and in the years that have followed its opening in 1931.

The functions of the Emma Pendleton Bradley Home are threefold. First of all it provides inpatient neuropsychiatric treatment for boys and girls up to twelve years of age. Preference is given to Rhode Island residents, but children are accepted from all parts of the country provided that they are within the age range, are of normal intelligence, and can presumably profit from what treatment is available. The Bradley Home also serves as a center for the training of professional personnel. Its third function is to sponsor scientific and clinical investigation and medical research.

Clinical Facilities

Residential psychiatric treatment for children is still in its early stages. Although the Bradley Home is the only independent hospital of its type, there are some half-dozen children's psychiatric wards in various parts of the country being operated as units of state and municipal mental hospitals. Several projects similar to the Bradley Home are being planned for the postwar period elsewhere. Considerable interest in the entire subject is commanding wide general attention, but the bulk of residential treatment is still being sponsored by social service organizations administering institutions and homes with psychiatric affiliations and consultation service instead of direct medical supervision.

Maladjusted children referred for hospital treatment are usually more seriously ill than those treated in private offices or community clinics. Their outstanding problems differ from those of the bulk of adult patients requiring psychiatric hospital care. Psychoses in childhood, although attracting considerable clinical comment just at present, are extremely rare. The debilitating and deteriorating diseases of old age are, of course, absent. Physical illness as a cause or result of emotional maladjustment in children is less conspicuous than in the adult group.

The Bradley Home meets the diagnostic and treatment needs of its patients by providing complete facilities for pediatric and psychiatric hospital care. Its greatest asset is a staff thoroughly oriented in children's work. In addition to medical and laboratory facilities and organization for group and individual psychotherapy, a full school and recreational program is provided for patients in the various age groups up to twelve years.

The hospital has a bed capacity of forty-eight, and up to January 1, 1946 nine hundred and ninety-nine children had been admitted. The primary diagnosis was behavior disorder in 55.8% of these, convulsive disorder in 14.3%, mental deficiency in 8.1%, and a variety of other diagnoses in lesser amounts. Special facilities for certain types of orthopedic care, notably in the field of cerebral palsy, were discontinued in 1942.

Professional Training

Opportunities for professional experience have been centered about a training program for physicians, which has now assumed residency status. The American Board of Pediatrics now gives credit up to six months toward certification for hospital experience at the Bradley Home. Arrangements are being completed for the teaching of undergraduate medical students in the near future. It is hoped that postgraduate training for nurses and psychol-

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BRADLEY HOME

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ogists may be resumed in the future, the war having interrupted previous plans for this.

Clinical Research

Research along several lines has been carried out for the past twelve years at the Bradley Home. The most notable contributions have been in electroencephalography, observations on the effects of drugs on children's behavior, and studies of the rare psychotic disorders of children. The activity of this program is reflected in the fact that seventy-five scientific articles have been published from this small hospital.

Following interruption of training and research activities by the war, a gradual resumption of the full threefold purpose of the Bradley Home has been under development for the past several months. Residencies have been resumed, research activities are again being undertaken or inaugurated, and directly and indirectly all therapeutic facilities have been stimulated.

News Items

Donald B. Lindsley, Ph.D., who has directed the psychological and electroencephalographic laboratory at the Bradley Home since 1938, has been appointed Professor of Psychology at Northwestern University, Evanston, Illinois, and will leave for his new post at the end of the summer. Maurice W. Laufer, M.D., who served as resident physician at the Bradley Home in 1942, has been appointed Clinical Director, which includes responsibility for the electroencephalographic program. Dr. Laufer is an accredited pediatrician with additional extensive neuropsychiatric and electroencephalographic experience in the Army Medical Corps. He will assume his duties at the Bradley Home upon his separation from the armed forces.

Eric C. Denhoff, M.D., who served a residency at the Bradley Home in 1941 and returned in recent months as assistant physician, has been appointed Director of Clinical Laboratories.

Visiting fellowships, primarily for the benefit of returned veterans, in the fields of pediatrics and psychiatry, providing training similar to that of residencies but of shorter duration, have been planned for the postwar period, and appointments running into the spring of 1947 have already been made.

The 1945 Annual Report of the Bradley Home contains specific information as to the treatment facilities available and procedures in regard to arranging admission for any child. Copies have been sent to all members of the Rhode Island Medical Society and the American Academy of Pediatrics. Further copies are available upon request.

CONSERVATION OF PULMONARY FUNCTION IN CHEST CASUALTIES

continued from page 592

tain special cases where localization is difficult a pneumothorax or pneumoperitoneum may decide the location of the foreign body.

Foreign bodies in the anterior surface of the lung may be removed by incising the intercostal bundle. If necessary to obtain better exposure one or even two costal cartilages may be incised, thus allowing greater retraction of the ribs. Foreign bodies in the posterior aspect of the lung are removed by subperiosteal excision of a small portion of the rib overlying the foreign body and incising the underlying periosteal bed.

Once the exposure has been obtained, the foreign body may be located by palpation in the majority of instances. The fibrous tract left by the missile may be palpated down to the foreign body in some instances. Lacking definite identification of the foreign body, a needle may be inserted to elicit the characteristic resistance offered by the foreign body. Once located, the visceral pleura immediately overlying the foreign body is incised and by blunt dissection a tract is established with a forceps and the foreign body is grasped and removed. The defect left by the foreign body is carefully debrided and using an atraumatic needle, mattress sutures are placed closing the defect in the lung. Following this the lung is fully expanded and the effectiveness of the closure is tested by dropping saline solution over the suture line. The thoracic cavity is then closed.

Ordinarily no drainage is necessary if the defect created by removing the foreign body has been adequately closed by suturing. Occasionally small amounts of air or serous fluid collect postoperatively. These can be easily handled by aspiration.

Conclusions

Metallic foreign bodies should be removed only when there is an indication that their presence will cause complication in the future. The mere presence of a foreign body is not disqualifying for duty.

Hemothoraces should be aspirated early and frequently enough to keep the pleural cavity dry and the lung fully expanded. Large hemothoraces that do not respond to aspiration should receive early decortication. This will give almost complete restoration of function to the lung and it is believed lower the incidence of empyemas.

Empyemas that are localized, small and have an underlying lung that is capable of fully expanding or empyemas in the patients too sick to stand a decortication are treated by open drainage. Large empyemas, originating in a clotted hemothorax, with a lung that is incapable of expanding because of a fibrin capsule are treated by thoracotomy and decortication.



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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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STREPTOMYCIN FOR CIVILIAN USE

Preliminary plans for limited commercial distribution of streptomycin after September 1st were outlined by Civilian Production Administration officials at a meeting of the Streptomycin Producers Industry Advisory Committee, CPA stated recently.

The plan, as outlined by CPA, will follow that used with penicillin. Streptomycin will be issued to selected hospitals throughout the country, and they will act as depots for their area. The amounts of streptomycin that will be distributed, and the particular hospitals have not been determined as yet.

Although CPA reported that the June production of streptomycin, as indicated from preliminary reports, was lower than expected, it is felt that a sufficient quantity will be on hand for the inauguration of the proposed plan on September 1, 1946. May production of streptomycin was 38,750.9 grams.

Until the final arrangements, supported by production reports, have been made for the new program, civilian appeals for this drug will continue to be met only from the limited supply available under the research program of the National Research Council. These appeals are judged on the basis of clinical information submitted by the physician in charge of the individual case to Dr. Chester S. Keefer, Evans Memorial Hospital, Boston, Mass.

Committee members said that the sponsoring companies will continue the financial support of the Research Council's clinical research on streptomycin until September. The additional cost will increase to nearly $1,000,000 the grants-in-aid to the Council by the streptomycin producers.

Dr. Keefer said that at present there is not sufficient streptomycin available to provide for the treatment of tuberculosis. Dr. Keefer said that experimental work carried on so far on tuberculosis gives increasing promise that the drug will find a definite place in the treatment of this disease. He emphasized however, that streptomycin will supplement, not replace, the present accepted methods of treatment.

Due to the limited production of streptomycin, he said, and the great quantities needed for treating this disease, its use must be restricted to research cases started before the setting up of the present program.

Dr. Keefer pointed out that treatment of individual cases of tuberculosis for the minimum period of three months cost about $4,000 for the drug alone.

AUGUST *Library Hours*

During the month of August the Medical Library will close daily at 1 P.M., except Saturday when the closing hour will be noon.

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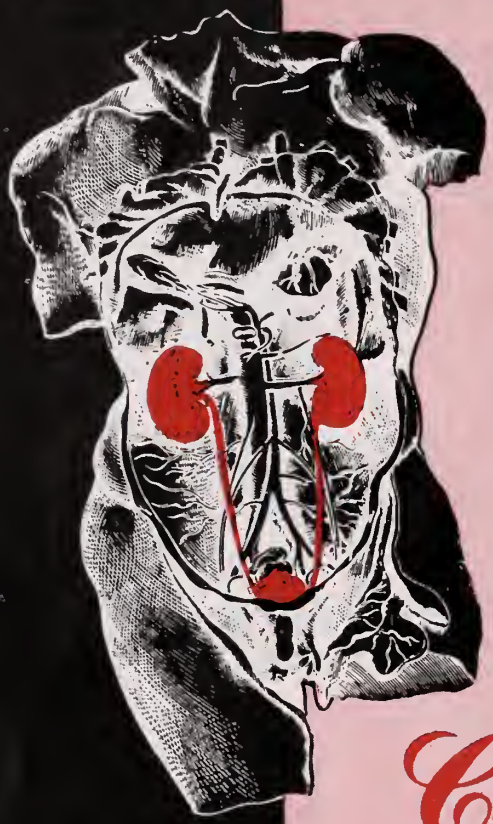
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BIBLIOGRAPHY: (1) Lehr, D.: Proc. Soc. Exper. Biol. & Med. 58:11, 1945. (2) Lehr, D.: J. Urol. 55:548, 1946.

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AMA ADOPTS RHODE ISLAND PROPOSALS RELATIVE TO COMPULSORY DISABILITY COMPENSATION

At the annual meeting of the American Medical Association at San Francisco, July 1—5, the House of Delegates unanimously accepted recommendations made to it by the Rhode Island Medical Society relative to compulsory disability compensation programs. The resolution adopted at Providence at the meeting of our House of Delegates read:

"Resolved that the House of Delegates of the American Medical Association review and amend the action taken at its meeting in September, 1938, at Chicago, on the subject of insurance against the loss of wages, and be it further

"Resolved that the American Medical Association through the proper Council or Bureau make a complete study of the existing and proposed compulsory temporary disability compensation programs, and that it report the findings of such a study, particularly as regards medical phases of the programs, to each of the constituent state medical societies before January, 1947."

The resolution was presented to the American Medical Association by Dr. Alex M. Burgess, delegate from Rhode Island. Subsequently Dr. Burgess and John E. Farrell, executive secretary of the Society, appeared before the reference committee of the AMA House of Delegates on legislation and public relations. This committee, headed by Dr. James Hamilton of Illinois, consisted of Dr. Hugh P. Smith of South Carolina, Dr. Deering G. Smith of New Hampshire, Dr. C. B. Conklin of the District of Columbia, and Dr. Elmer Hess of Pennsylvania.

The action of the House of Delegates in 1938 when it reviewed the proposed national health program and endorsed the principle of cash compensation for loss of wages due to non-occupational sickness or accident was subject to discussion before the Committee. It was pointed out by the Rhode Island representatives that in 1938 the House of Delegates expressed its opinion that in a cash disability compensation program the attending physician should be relieved of the duty of certification of illness and recovery, which function it believed should be performed by a qualified medical employee of the disbursing agency. The impossibility of this arrangement without making every physician a state employee was cited as reason for the need for reconsideration of the action in the light of the experience in Rhode Island of the cash sickness compensation plan.

Mr. Farrell reviewed the three types of state disability compensation in existence or proposed, citing the medical phases of the Rhode Island plan, the cash sickness and disability insurance act passed by California last February, and the non-occupational accident and sickness benefits law proposed to the legislature in New Jersey in April.

On July 2 the reference committee made its report to the House of Delegates, stating that it had carefully considered the Rhode Island proposal and was unanimously in agreement in recommending that the House rescind its previous opinion relative to the certification of illness and recovery under compulsory sickness compensation plans, and also in recommending that a study be made of the medical phases of existing and proposed plans of this type of compensation for the benefit of each state medical society.

The House of Delegates unanimously adopted the report of the reference committee on this subject. In all probability the study will be undertaken jointly by the Council on Medical Service and Public Relations, the Council on Industrial Health, and the Bureau of Medical Economics.

SICKNESS ACT COMMITTEES NAMED

Recently Governor John O. Pastore, in accordance with provisions of amendments to the Cash Sickness Compensation Law made by the General Assembly at its recent session, named Dr. John F. Kenney and Dr. Albert H. Jackvony to serve on special study committees. Dr. Kenney, immediate past president of the R. I. Medical Society, will be the physician member of a three member Board of Review of cases appealed, and Dr. Jackvony, former President of the Providence Medical Association, will represent the medical profession on the 7-member Advisory Committee that is to review the sickness compensation program monthly.

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WOONSOCKET MEDICAL SOCIETY

A meeting of the Woonsocket Medical Society was held at the St. James Hotel on Tuesday, June 18. The meeting was called to order by President H. Lorenzo Emidy at 9:30 p. m.

The president appointed a nominating committee of Dr. Victor H. Monti, Dr. George Crepeau, Dr. Joseph McKenna, Dr. Virgilio Bertone, Dr. Thomas Lalor to present a slate of officers to serve the Society for the next twelve-month period.

The secretary presented applications for membership in the Society from Dr. George Vian and Dr. Harry Jacobs. Motions were made, seconded and unanimously adopted electing both physicians members of the Society.

Dr. Emidy presented Mr. John E. Farrell, executive secretary of the Rhode Island Medical Society who reported on the status of the Society's Voluntary Prepaid Surgical Insurance Program, and also discussed the amendments made to the Rhode Island Cash Sickness Compensation Act and the actions taken by the Society relative to the proposed new Health Code. Mr. Farrell answered many questions submitted by members of the Society on the various topics presented.

The motion was made by Dr. Crepeau, seconded by Dr. McKenna and unanimously passed that the dues for each active member for the ensuing fiscal year should be raised to make the total assessment $5.00 per member.

Dr. Monti reported for the nominating committee the following slate of officers for the ensuing year: Dr. Joseph Reilly, president; Dr. Richard Dowling, vice-president; Dr. Alfred King, secretary; Dr. Paul Boucher, treasurer; Drs. James McCarthy, councillor, and Saul Wittes, alternate councillor; Drs. H. Lorenzo Emidy and Francis King, delegates; Drs. E. L. Tremblay, George Crepeau and Joseph McKenna as censors.

After thanking the members for their support of his administration during the past year, Dr. Emidy appointed Dr. Lalor as a committee of one to escort the new president to the chair. Dr. Reilly thanked the members and expressed the hope that the Society may meet more regularly during the coming months.

Attendance — 20.
Collation was served.

Respectfully submitted,

Paul E. Boucher, M.D., *Secretary*

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Feinberg, S. M.: Allergy in Practice,
Chicago, The Year Book Publishers, Inc., 1944, p. 502.

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77th ANNUAL MEETING — CANADIAN MEDICAL ASSOCIATION

ALEX M. BURGESS, M.D.

THIS IS A report on the 77th annual meeting of the Canadian Medical Association, which was held at Banff, Alberta, from June 10th to June 14th, 1946. It was my privilege to represent the American Medical Association at this meeting and to attend most of the sessions of the General Council, which corresponds to the House of Delegates of the American Medical Association.

It seems to me that the action and the attitude of the Canadian Medical Association on various topics is of considerable value to the American Medical Association and I therefore made a brief written report to Secretary Lull of the American Medical Association, enclosing the Confidential Committee reports of which I was given a copy. In the main the reports were adopted about as they appear in that document and, in general, it may be said that the attitude of the profession in Canada is similar to that in our own country.

I had the opportunity to talk to several of the officers of the Association at some length and, in general, their attitude on the subject of State Medicine and Compulsory Sickness Insurance is similar to that of the American Medical Association. Dr. MacPhedran, Chairman of the General Council, said that he felt it would be an excellent thing if the Canadian Medical Association and the American Medical Association could get together so that their common point of view on these topics could be compared, and if it could be brought out that the profession of these two countries held the same attitudes it might be of mutual help in this situation.

The report of the Committee on Medical Economics is of particular importance. It is evident that profound changes in medical practice are occurring in Canada and that the medical profession is doing a good job in guiding and controlling, although it cannot, and evidently does not wish to check the revolution which is going on and which it regards as inevitable and necessary. The principles which it has laid down in the published reports are, I believe, worthy of study and creditable to the medical profession.

In British Columbia ten years ago an unsound act legalizing State Medicine was passed and could not be implemented because of the opposition of the profession. Two years ago, in Saskatchewan, a Socialist Government was elected on a platform of State Medicine but public opinion has become better informed and has turned against the program. It now demands State-Aided Health Insurance. Federal aid is extended to all the provinces and the medical profession is holding out for and in a fair degree obtaining a control of the situation. In Saskatchewan fourteen health centers are being established with Federal Aid, each to furnish diagnostic and therapeutic service. It is to be remembered that Saskatchewan is the middle one of the prairie provinces and that it is quite similar both in its geography and in its population to the Dakotas. Already one hundred salaried municipal doctors are, I understand, starting work on contracts in the various cities and towns in Saskatchewan. The Government will give funds to any municipality which will offer to physicians contracts of a standard approved by the Medical Commission. It may be said that the Medical Commission has been treated pretty well by the authorities and that it is gaining most of its objectives in most of the provinces. I feel that these developments should be studied in our country. I was particularly impressed by what was said by Dr. A. D. Archer of Lamont, Alberta, who is Consultant on Medical Economics for the Canadian Medical Association, and who knows more about these developments than anyone else.

The scientific program, as far as I was able to attend it, was a fairly good one. There was no scientific exhibit and the commercial exhibit was somewhat limited.

The convention in the beautiful Canadian Rockies was an extremely pleasant meeting. The accommodations, however, were insufficient for the number of physicians who wanted to attend and at least a thousand were turned away.

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N. E. INDUSTRIAL NURSES MEET

The industrial nurses of New England held an Annual Spring Conference June 29th and 30th at the Mount Washington Hotel, Bretton Woods, N. H. Ruth Estee, R.N., represented J. & P. Coats (R.I.) Inc. at that meeting. Dr. S. Sprague, was also present in a triple capacity, as Medical Director of J. & P. Coats (R.I.) Inc., as Vice-President of the New England Conference of Industrial Physicians and Surgeons, and also as Chairman of the Industrial Health Committee of the Rhode Island State Medical Society.

Approximately two hundred nurses were present at this Conference, which was carried on in a business like and prompt manner.

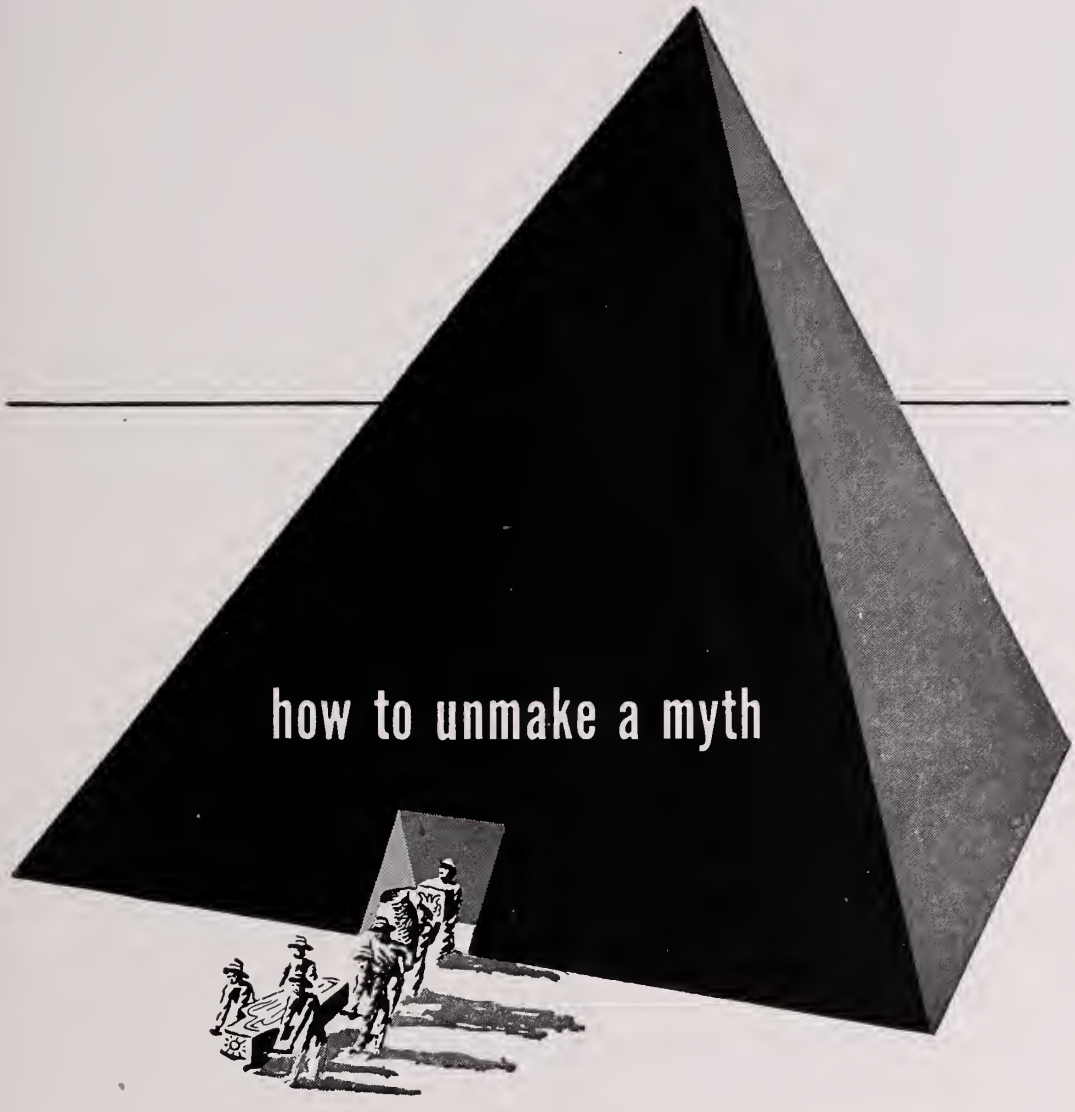
The speaker of the afternoon session on Saturday, June 29th, pointed out to the assembled nurses the varying conditions for which they should watch as the results of many new dyes, plastic, gasses, and solvents which are now being used in varying plants throughout the New England area. He pointed out the symptoms which they should watch for and to be sure that they themselves were as familiar as possible with the chemistry of these various things insofar as it might affect the health of the workers. The subject was a bit on the long side and in many ways was very interesting but in other ways it was a little too highly technical for a gathering other than scientists.

The dinner in the evening was attended by over three hundred people. The Governor of the State of New Hampshire extended brief greetings. The Honorable Sherman Adams, Congressman of the United States from New Hampshire, spoke on the relation of "The Nurse, the Doctor, and the Government". His talk was very excellent and he gave the impression to the writer that he is much more in favor of medical health work to be done through the medical associations rather than to have socialistic medicine as put forth in the so-called Murray-Dingell Bill. He aroused large applause by his words and he was very well received.

Dr. Arnold Hansen, Ph.D., Director of Labor Relations of Brown Company, Berlin, N. H., spoke on "The Nurse in Industrial Relations". The gist of his talk was to point out the value of the nurse in industry, and he spoke to the point on the many qualities of sympathy, efficiency, courtesy, neatness, etc., which every industrial nurse should endeavor to attain in order to retain kindly relations between the employee and management.

Words of greeting were also extended by Catherine R. Dempsey, R. N., who is the President of the American Association of Industrial Nurses, Georgianna Bergen, R. N., President of the New England Industrial Nurses Association, and Queenie LaBrecque, R.N., who is President of the New Hampshire Industrial Nurses Association.

continued on page 618



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1. Am. J. Dis. Child. 66:1 (July) 1943

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INDUSTRIAL NURSES MEET

continued from page 616

Dr. Sprague was introduced as the Vice-President of the New England Conference, but, due to the lateness of the hour, acknowledgment of the introduction only was given.

Sunday morning a breakfast meeting at 9:00 o'clock was held and the speaker was Mr. Kenneth Gould, meteorologist from the Weather Observatory on Mount Washington, who spoke about "The World's Worst Weather and How It Is Recorded". His talk lasted about an hour and was full of actual data and a considerable amount of humor in the varying situations which sometimes arise in his work.

Following this meeting, the Conference was adjourned and notification given that the Fall Conference was to be held at the Hotel Kimball in Springfield in the last week in October of this year.

AMA HOUSE OF DELEGATES

continued from page 598

West by making him President-elect the House has fittingly recognized his long years of service to American medicine and the wisdom and experience which he has gained. The unanimous choice of Dr. Edward Bortz of Philadelphia as vice-president is, in the opinion of your delegate, a most happy one. The contest for speaker lay between two very experienced and able men, Dr. R. W. Fouts of Nebraska, who has served for many years as vice-speaker and was made speaker a year ago, and Dr. Lowell S. Goin of California, who has shown great ability as speaker of the California House of Delegates and whose able testimony before the Senate Committee considering S-1606 (the Wagner-Murray-Dingell Bill) has won the praise of the profession generally. Dr. Goin received slightly more than two-thirds as many votes as did Dr. Fouts.

The invitation to hold the 1949 session in New York City was presented by the delegation from the State of New York and was accepted. It has been already announced that the 1947 meeting will be held at Atlantic City and that in 1948 at St. Louis.



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THE MEDICAL AUDIT*

HENRY S. JOYCE, M.D.

The Author. *Henry S. Joyce, M.D., of Providence. Assistant Superintendent, Rhode Island Hospital.*

AN AUDIT is the examining of records of account and its purpose is to determine the course of the enterprise under scrutiny. Its history goes back for four hundred years or more, when the process had its first beginnings. All business firms whether manufacturing, merchandising or banking must have this done to find out where they have been, where they are, and where they are going. Corporations that provide service such as hospitals must have their financial affairs audited if management is to operate intelligently. The service to patients in hospitals is subject to the same type of evaluation after scrutiny and this must be done by those who are expert in the field. The records which must be examined are the histories of patients treated within the walls of the institution. It is the responsibility of the record librarian to preserve these and make them available for study; it is the responsibility of the medical staff to evaluate the service to patients by the evidence in these histories.

Of course, it is a basic truth that the audit can be only as good as the records are complete. It has been repeatedly pointed out that there are many good reasons why time and effort should be spent in writing the clinical records of patients. It is not my purpose to enumerate them at this time. However, it is my firm conviction that good records are essential for the best care of the patient.

The first item in the record, the admission history and physical examination should be expertly done and clearly described. This gives a resume of the health history of the patient from birth up to the present illness and all details of the condition for which he seeks treatment. Only when all these are recorded can a clear picture of the clinical condition at the beginning of treatment be drawn. These may be evidence sufficient to make a diagnosis at once, possibly with a chief disease and other secondary ones, which may be serious or trivial. For example, a carbuncle, which being on the exterior of the body, may be diagnosed with some certainty. The history may reveal that the patient also has diabetes, perhaps it does not but a simple examination of the urine will soon determine if that disease presents a complication. Even a carbuncle may present a diagnostic problem in itself. Cutaneous anthrax looks much like a carbuncle, it has a more brawney induration which is wider in extent, it has a necrotic center which is harder, darker in color, and dry—usually there is a widespread edema about it, the patient is usually sicker. I have seen such a patient walk to the hospital and ask "to have this boil fixed." Yet he died within thirty-six hours of generalized anthrax. The occupational history in such a case is important in the differential diagnosis since this infection of the skin is usually found in those who handle animal hair or hides. The man just mentioned carried bundles of hides on his shoulder at his work.

Moreover, a single examination of the urine which shows the presence of some reducing substance does not prove the presence of diabetes. A substance other than glucose may give a positive reaction or there may be glucose present, but due to a low renal threshold or renal diabetes and not diabetes mellitus. This can be determined by the blood glucose level at the time the urine was excreted; if within normal limits renal diabetes is present, if abnormally high, it is due to true diabetes.

The past history of the patient, also the family history may provide a clue as to the presence of diabetes. The fact that the parents or siblings of the patient have had the disease should at least raise the suspicion that he also might have it. There are typical symptoms which point rather definitely to this metabolic disorder—some that are common to others such as hyperthyroidism or a tuberculous infection. When these items are carefully sought for and recorded the diagnosis or diagnoses and the differential diagnoses begin to take form.

The physical examination should be as complete and detailed as possible. Missed diagnoses are rare but are due more to not looking for signs than to misinterpreting signs that are found. I well remember a middle-aged woman sent to the hospital with a diagnosis of "acute abdomen" and although examination of her abdomen was absolutely negative, she gave a history of symptoms suggesting high

continued on next page

* Presented at the Annual Meeting of the Rhode Island Association of Medical Record Librarians, at Providence, May 15, 1946.

intestinal obstruction. Her temperature was normal, so was her pulse rate and one was tempted to call it gastro-intestinal disturbance in a neurotic person. But—her pupils gave the Argyll-Robertson reaction and her knee jerks were absent pointing definitely to the presence of Tabes Dorsalis and the suspicion that the pains were caused by tabetic crisis. Later laboratory tests and the course of the disease confirmed this diagnosis.

A description of the nutritional and mental state of the patient is always helpful. The first can be roughly approximated by the weight and height when they are recorded but the color of the face and mucous membranes and texture of the skin are valuable indeces in many diseases. That reminds me of a diagnosis made by the color of the face. The patient's chief complaints were cough, loss of weight and some, but not marked, shortness of breath on exertion. This pointed to disease in the chest but no definitely abnormal signs could be found either in the heart or lungs; certainly not enough to account for his symptoms. In addition and as an after thought, he spoke of some distress after meals which had been present for a month or so. The chest examination had been made with the patient in the sitting position but the abdominal was done in the supine. So soon as he laid down his face became blue and got bluer and swollen. Simple change of position had produced marked congestion of his head and neck—this pointed to a mediastinal tumor which fell back and pressed on the veins in the upper thorax. X-ray examination showed a solid tumor in the middle of the thorax without lateral extension which explains why there were so few signs on physical examination.

Another patient comes to mind in which the diagnosis was based on the color of the mucous membranes but also illustrates how the history and physical examination aids in your diagnosis. The patient was a small girl aged five or six years. Her appearance was most striking; her lips and finger tips were deep blue, not just ordinary cyanosis, but a blue with no perceptible red in it. First impression—congenital heart disease—but no—before examining her chest you note that she is perfectly comfortable and composed—no hurried breathing at all, no visible pulsations in the neck. How long has she been of this color? the mother answers "only this morning". To the child, "How do you feel?" Answer "all right". Examination of the heart and lungs shows no abnormal signs at all. It is Sunday and the child is daintily dressed but you note that she wears dark shoes. This brings to mind that shoe dye solvents are absorbed through the skin and produce methemoglobinemia. Then it is ascertained that the little girl's shoes were dyed that morning and put on to wear before the dye had dried. That was the cause of her symptoms—absorption of the dye solvent which would not have occurred if time had been allowed for it to evaporate before wearing her shoes.

The rest of the physical examination must be done with full use of eyes, ears and sense of touch. The record should show positive evidence that this has been carried out. Then decision must be made as to what examinations in the X-ray Department or Laboratory are needed to supply the information needed for a positive diagnosis. Some tests need be done on all patients, others as indicated by the possible diagnosis. The record should show that these have been wisely chosen and promptly done.

An emergency blood glucose determination has given the diagnosis in many situations which come up suddenly. One patient comes to mind who had a period of mental confusion such that a history was not obtainable. Fortunately a vial of insulin was found in his pocket which suggested that he might have diabetes. His blood glucose was very low, his confusion cleared after he received some intravenously. Then we found that he was a diabetic using protamine insulin. When his blood sugar returned to normal he was normal.

Aside from examinations which are needed to determine the chief pathological lesion others need be done to determine secondary effects which are of importance. An instance which comes to mind is that of onset of hemorrhoids in a middle-aged person, who never had trouble of that sort before. Proctoscopic and x-ray examinations are indicated on the suspicion that the first lesion is a secondary effect of a cancer of the sigmoid or rectum. Many times this has proved to be true. Then to find out how much damage such a process has done to the body one must do thorough studies of the blood, both cellular contents and chemical determinations.

All forms of treatment should be shown in sufficient detail so that an exact picture is drawn and the immediate and remote effects are described. All complications and progression or regression of the original lesions should be described as objectively as possible.

Our new therapeutic agents give us wonderful control over many infections that formerly ran their course but little influenced by drugs with specific action. Many patients were saved by general measures deigned to foster the effects of the natural defenses of the body. But now we have agents that attack the organisms causing disease—although there are many infections not influenced by them at all. We also have new drugs which favorably influence metabolic disease—thiouracil is an example. There are many others on which much research has been done as to their actions and therapeutic effects. These require exact observation and recording. The deleterious effect of many

continued on page 625

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Richards, R. K., and Perlstein, M. A. (1945), Tridione, A New Experimental Drug for the Treatment of Convulsive and Related Disorders, Proc. Chicago Neurological Soc., Jan. 9; and (1946), Arch. Neurol. and Psychiatry, 55:164, February.

Lennox, W. G. (1945), Petit Mal Epilepsies: Their Treatment with Tridione, J. Amer. Med. Assn., 129:1069, December 15.

DeJong, R. N. (1946), Effect of Tridione in the Control of Psychomotor Attacks, J. Amer. Med. Assn., 130:565, March 2.

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D21

THE MEDICAL AUDIT

continued from page 622

of them is on the blood forming organs which shows whither one should look when using the drugs in full doses. One can then shift to another drug without this toxic effect or, strange as it may seem, one may continue to use the same drug and the disturbance in blood formation will clear up. In some cases this proves to be true but it would probably be safer to switch to another one.

Records that are complete and accurate are essential for an audit. The procedure varies in hospitals but the purpose and results are the same. One small hospital has a weekly review of all records by the auditor with the Chairman of the Staff and the Record Committee. Each Staff member is Auditor for one month in rotation which certainly is an equable way of doing the work. It achieves two purposes—each one shares in the responsibility and in the opportunities. It also improves the Auditor's concept of a good and complete record. All cases are classified as to type, risk and result obtained. Errors in diagnosis, treatment, judgment and technique are looked for.

When errors or omissions are found a confidential note is sent to the physician responsible with suggestions from the group. The Record Librarian is given this information and she must see that the doctor makes the suggested change before the record is indexed and filed. A monthly summary report is made to the Staff. All deaths of patients are classified as inevitable, justifiable or non-justifiable.

Another method which applies particularly to the Surgical Services is the review of the month's work at a closed meeting of the Staff wherein all deaths are discussed. The surgical pathology is made note of particularly. Complications such as wound disruption, sepsis, infarctions, emboli, hemorrhage, etc. are also discussed. Reports of results in specific diseases are assigned to members of the Staff for purpose of comparison with previous years. The results found in follow-up clinics are also the basis of some reports. The Chief of the Service is the responsible person in such an organization. He makes an annual report to the Superintendent and Trustees; he also must decide when a member of the Staff has poor results, whether he should be trained to do better work or be dropped from the Staff.

In the larger hospitals the volume of work that needs be reviewed precludes the use of all records and opinion has been expressed that those of patients who died constitute a fair example. If the care of these patients has been good, it is inferred that in general the patient care is good.

The American College of Surgeons has formulated a method of audit and states the way the information so obtained should be used. The organization includes an active Record Committee, a professional accountant and a Qualification Committee. The first named, the Record Committee, must see that the members of the Staff make complete records on all cases, and make a statement at the time of admission of their estimates of the risks in terms of Good, Fair and Bad under the three categories of Elective, Emergency and Palliative. When the record is complete, the professional accountant reviews it critically and states his opinion of the management and result. Those approved by him are indexed; those that are debatable are referred to the Qualifications Committee for further evaluation and this Committee may refer to the full Staff, if they so desire. When this process has been completed the Record Librarian may then make up the Physician's Index which records the performance in summary of each member of the Staff. On the basis of this index, granting of privileges, promotions and appointments may be made, with adequate judgment.

The medical audit then is a method of self appraisal by members of the Staff of a Hospital; the basis of which is complete and detailed clinical records; the purpose of which is improvement in the care of the patients by full use of knowledge gained by experience.

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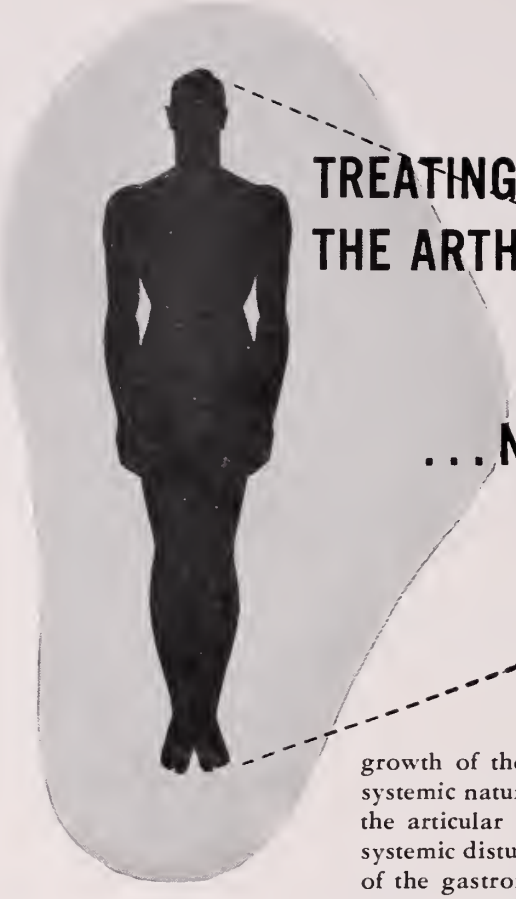
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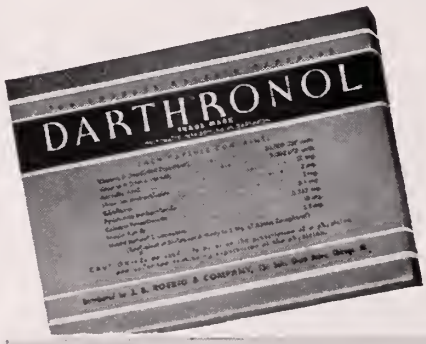
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THE PEPPER BILL

With the all-out effort by the Administration to enact the Wagner health measure it was generally assumed that there would be no action on S.1318, Senator Pepper's maternal and child welfare act. However, when it became evident that the Wagner proposal was doomed for this year, Senator Pepper revived his bill. Hearings were held June 21 and 22 and little opposition was expressed by the witnesses, except that by Drs. Joseph Wall and Joseph Howard, the latter of Bridgeport.

Among other things S.1318 would provide "free" medical services for some 43 million children and 3 million mothers during the maternity period, and thus would nationalize medicine for approximately 40% of the population. If enacted the bill would establish the principle that the Federal government is to furnish medical care as a tax-supported public service for all persons in certain segments of the population whether or not they are able to pay for such services themselves.

Consideration on the bill was laid over until July 15, and on that date the Senate Committee on Education and Labor instructed Senators Pepper and Taft to introduce a joint resolution amending title V of the Social Security Act to provide for increased grants to states for maternal and child health care, for crippled children, and for child welfare services. This resolution, serving as a temporary substitute for the Pepper act, will provide for sizable increases in the appropriations for the already existing programs.

FEDERAL SECURITY AGENCY RE-ORGANIZED

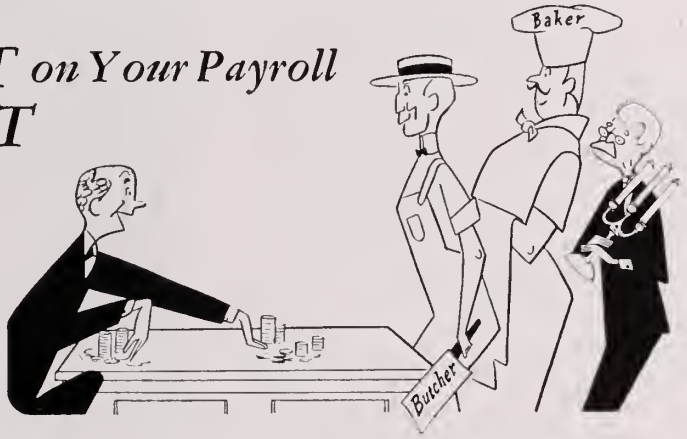
With the enactment by Congress on July 16 of the Re-organization Plan No. 2, with the Senate vote a close 40-37 one in favor of the program, the U. S. Employees Compensation Commission, the Children's Bureau (which administered the EMIC program), and the Division of Vital Statistics are transferred to the Federal Security Agency headed by Watson B. Miller.

The Agency is now to be constituted, according to Miller, under four main operating branches and six offices. The branches are Social Security Administration, headed by Arthur J. Altmeyer who has been chairman of the Social Security Board now abolished, with Miss Katherine Lenroot continuing as chief of the Children's Bureau; Education, to continue under the direction of John W. Studebaker, Commissioner of Education since 1934; Public Health, of which Surgeon General Thomas Parran will continue as head; and Office of Special Services, a new office to be directed by Mrs. Jewell W. Swofford, chairman of the U. S. Employees' Compensation Commission since 1933.

George E. Bigge, former Providence resident, and member of the Social Security Board since 1937, will head the new office of Federal-State Relations, and Mrs. Ellen Woodward, another member of the SSB, is to head the Office of Inter-Agency and International Relations.

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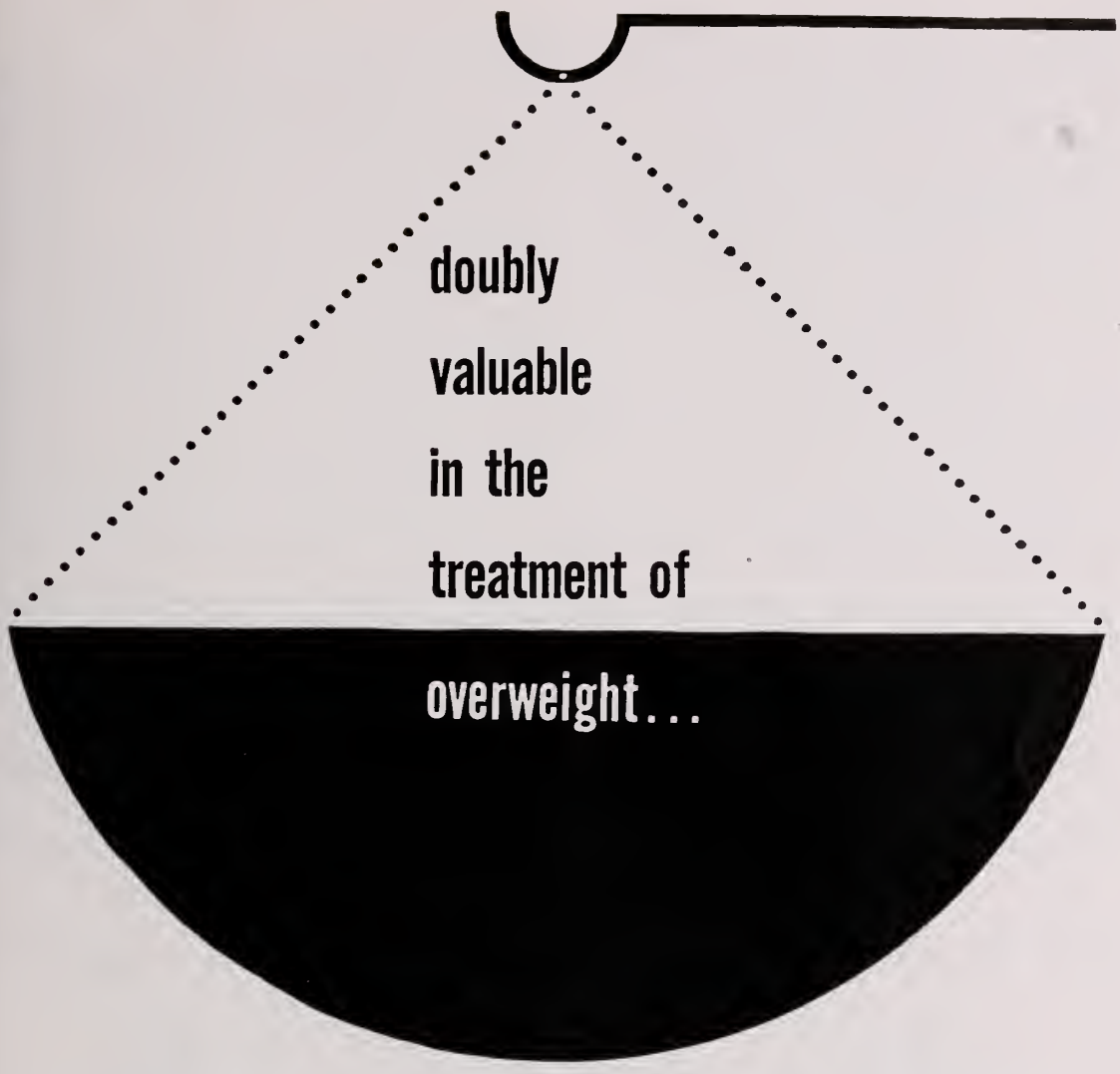
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Society	*Delegates*	*Councillor*	*Officers*	*Meeting Dates*	*Annual Meeting*
Kent County Medical Society	Rocco Abbate	Fenwick Taggart	President, Whitman Merrill Vice President, P. Erinakes Secretary, J. E. Vidal Treasurer, John A. Mack	2nd Thursday of each month	December
Newport County Medical Society	James C. Callahan Samuel Adelson	Norman M. MacLeod	President, A. M. Tartaglino Vice Pres., Wm. A. Stoops 2nd Vice Pres., P. P. Ciarla Secretary, H. W. Brownell Treasurer, N. U. Zielinski Censors: N. M. MacLeod John A. Young	4th Tuesday of every other month—Jan., Mar., May, July, Sept., Nov.—usually no July meeting held	January
Pawtucket Medical Association	Earl J. Mara Robert Henry Charles L. Farrell Henry Hanley	James L. Wheaton Earl F. Kelly (alternate)	President, Wm. N. Kalcounos Vice Pres., Earl J. Mara Treasurer, L. A. Senseman Secretary, K. W. Hennessey	On or after 3rd Thurs. of each month at time and place designated by the Pres. (except July-August)	March
Washington County Medical Society	Linwood H. Johnson Julianna R. Tatum	John P. Jones	President, S. P. Turco Vice Pres., Louis Morrone 2nd Vice Pres., S. A. Capalbo Sec'y-Treas., J. R. Tatum	January, April, July, October—on second Wednesday of the month	January
Woonsocket Medical Society	H. Lorenzo Emidy Francis King	James McCarthy Saul Wittes (alternate)	President, Joseph Reilly Vice Pres., Richard Dowling Secretary, Alfred King Treasurer, Paul Boucher Censors: E. L. Tremblay George Crepeau Joseph McKenna	2nd Tuesday, alternate months, Sept.-June	Elective
Providence Medical Association	Bertram H. Buxton H. G. Calder A. V. Migliaccio A. Henry Fox Arcadie Giura Alex. M. Burgess Emery M. Porter Henry E. Utter George W. Davis Kalei K. Gregory Edward V. Famiglietti Peter F. Harrington	Emery M. Porter	President, Paul C. Cook Vice Pres., Guy W. Wells Secretary, Frank Cutts Treasurer, Wm. P. Davis	1st Monday of each month; Oct.—May inclusive	January

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Society	*Officers*	*Annual Meeting*	*Chairman, Elected Committees*
Rhode Island Medical Society	President, Herman C. Pitts Vice President, Michael H. Scanlon President Elect, Arthur H. Ruggles Secretary, Morgan Cutts Treasurer, Charles J. Ashworth Ass't Secretary, Charles B. Ceppi Ass't Treasurer, G. Raymond Fox	May 15 and 16, 1946 at Rhode Island Medical Society Library, 106 Francis Street Providence 3. R. I.	Philip Batchelder and Merle M. Potter, Auditors Stanley Sprague, Committee on Industrial Health Russell S. Bray, Committee on the Library Alex M. Burgess. Committee on Postgraduate Education Arthur H. Ruggles, Committee on Medical Economics William H. Foley, Committee on Public Laws Guy W. Wells, Committtee on Public Policy and Relations John E. Donley. Committee on Publication Herman C. Pitts, Committee on Scientific Work and Annual Meeting

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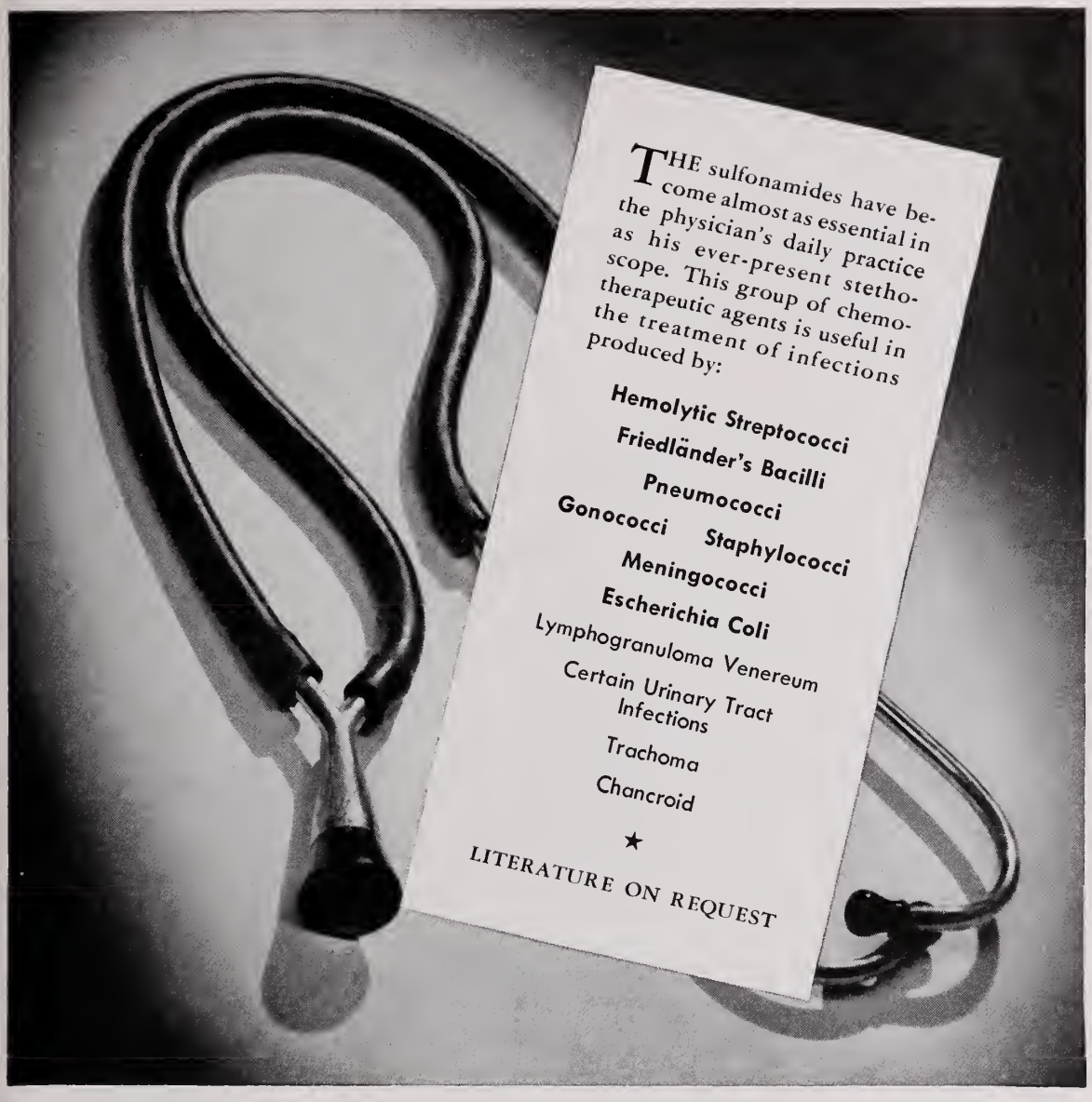
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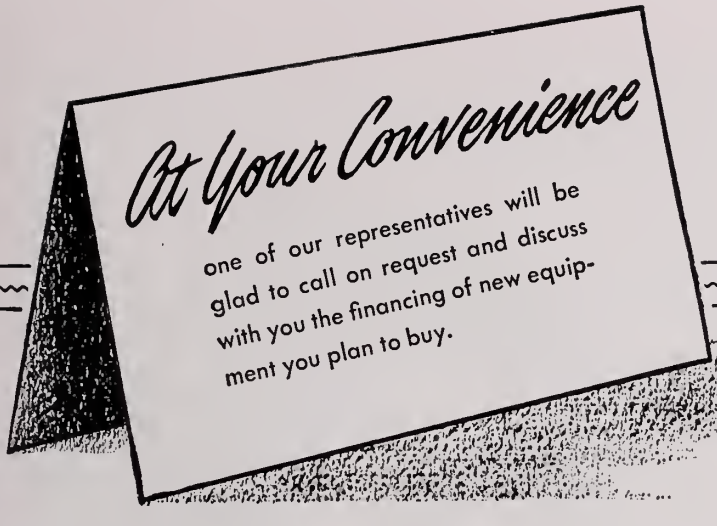
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THE RHODE ISLAND MEDICAL SOCIETY • HOSPITAL ASSOCIATION OF RHODE ISLAND

Volume XXIX, No. 9

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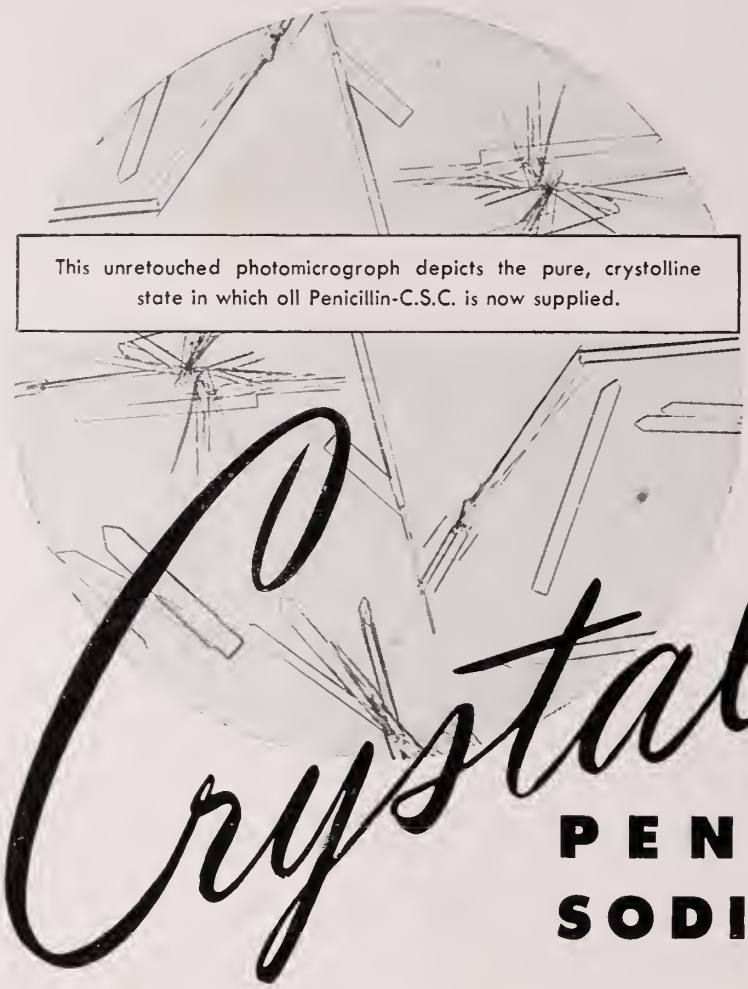
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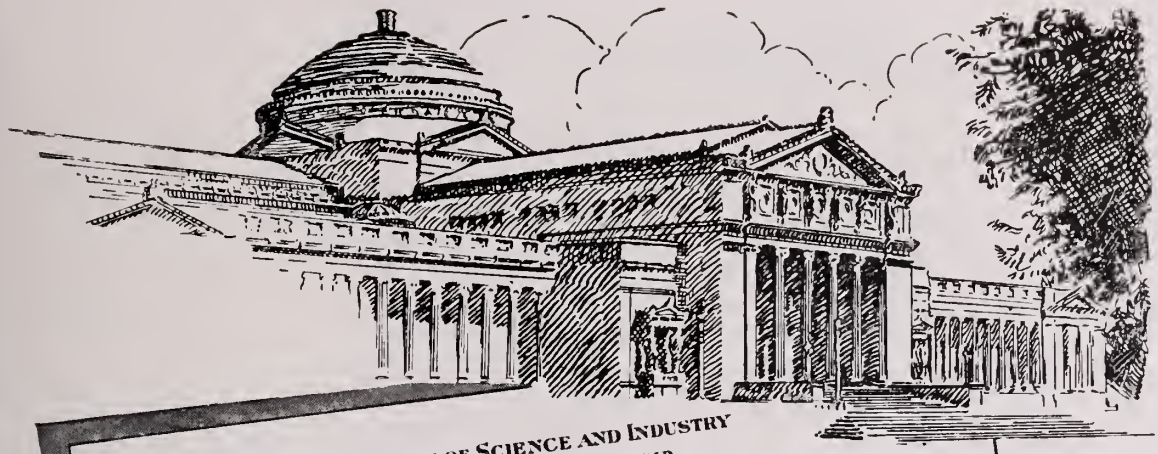
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I vividly recall the premier of the Transparent Woman at Rockefeller Center in New York City before a distinguished assembly of physicians, scientists and educators. Its later tour throughout the Nation under the auspices of state and county medical societies and academies of medicine was a significant contribution to public health education. You are to be congratulated not only on your sponsorship of this important and effective exhibit but also on the ethical manner in which it was presented to the laity through the profession.

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1. Follis, R. H. Jr.; et al: Am. J. Dis. of Child., *66*:1-11 (July) 1943.

2. Moore, C. U.; et al: Am. J. Dis. of Child., *54*:1227-28 (Dec.) 1937.

3. Park, E. A.: Vitamin D Therapeutics. THE VITAMINS. A. M. A., Chicago. 1937.

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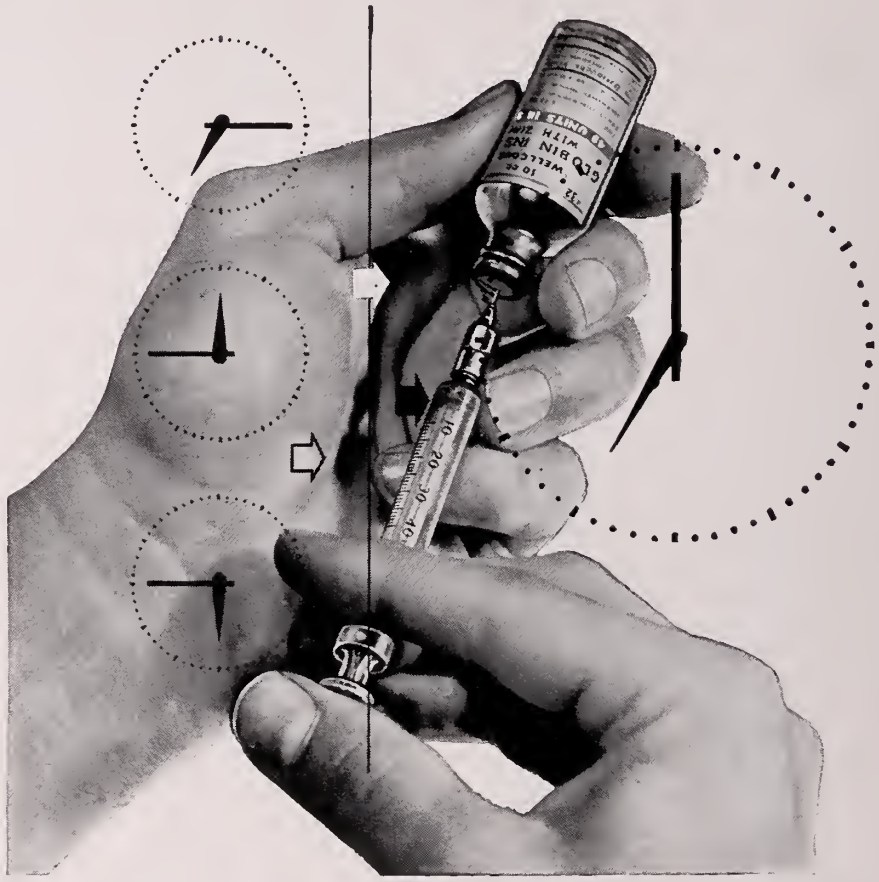
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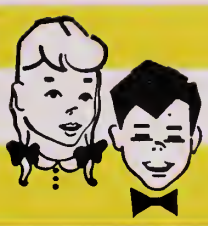
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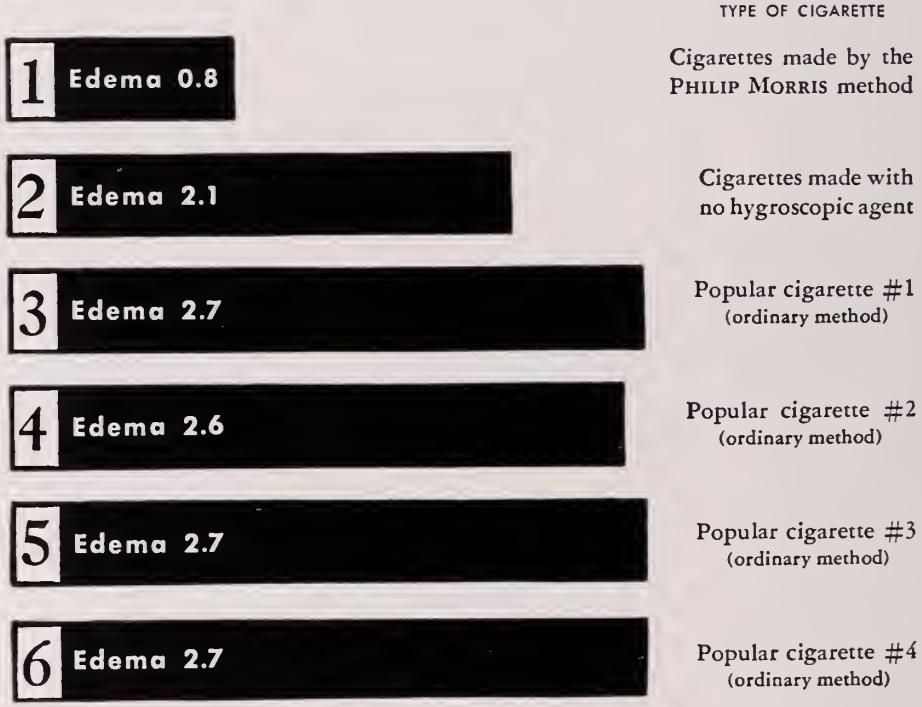
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*Strean, L. P., Beaudet, J. P.: New York State J. Med. 45:2183 (Oct. 15) 1945.

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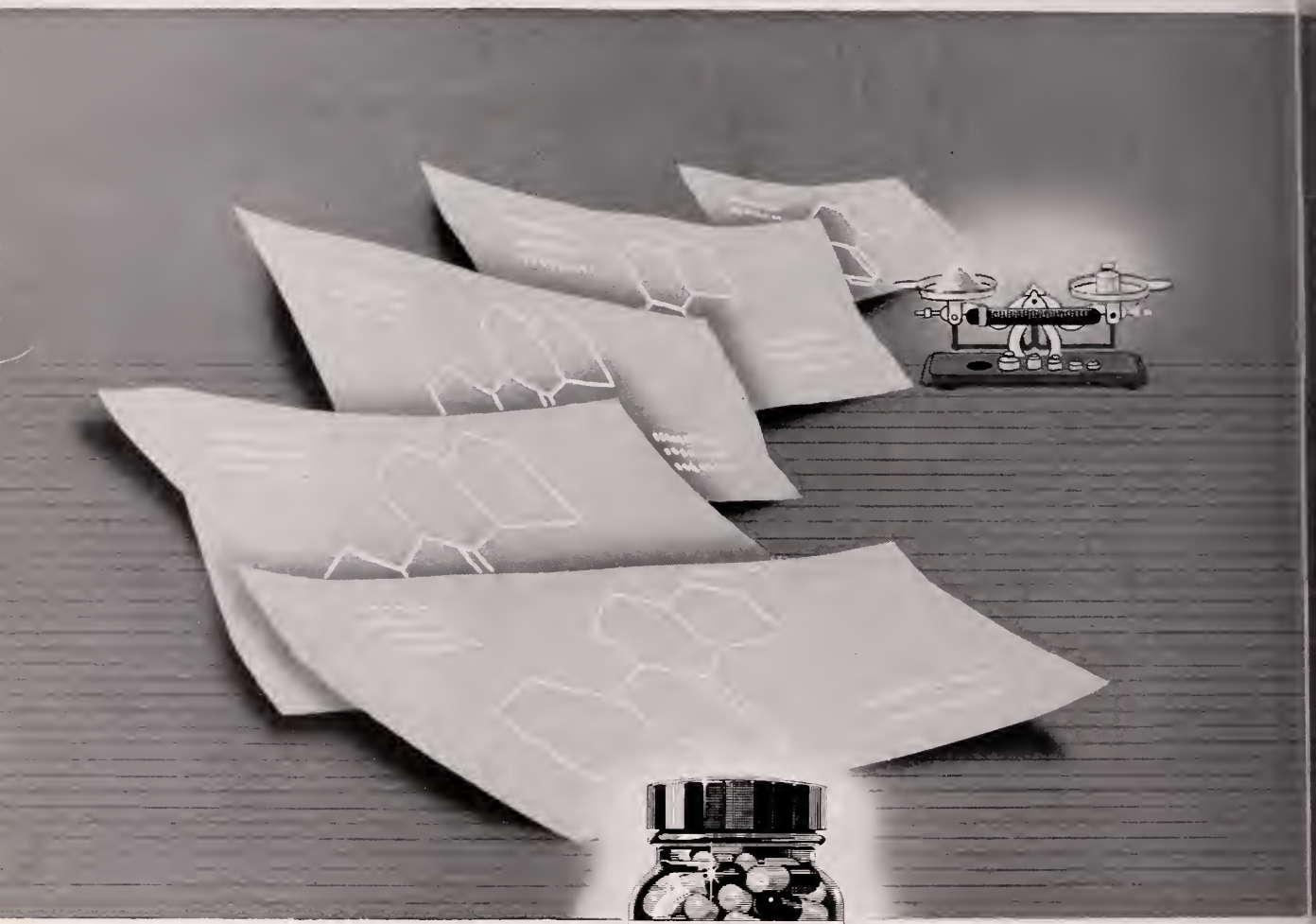
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXIX SEPTEMBER, 1946 NO. 9

SEVEN YEARS EXPERIENCE IN THE CONVALESCENT CARE OF RHEUMATIC FEVER*

JOHN P. HUBBARD, M.D.
LOUIS A. SIERACKI, M.D.
ISABELLE JORDAN, R.N.

The Authors. *John P. Hubbard, M.D., at present conducting a study of child health services under the auspices of the American Academy of Pediatrics; Louis A. Sieracki, M.D., Medical Director, Sharon Sanatorium; Isabelle Jordan, R.N., Superintendent of Nurses, Sharon Sanatorium.*

THE present discussion is based upon seven years of experience in convalescent care of rheumatic fever at the Sharon Sanatorium. Upon this background I wish to discuss some of the aspects of convalescent care in hospital, sanatorium or home.

In October 1938 many of us who were dealing with rheumatic fever were much concerned over the lack of facilities for rheumatic children. During the spring months it was not unusual for a large proportion of medical beds in hospital wards to be filled with rheumatic children. They could not be kept indefinitely in beds needed for acute illnesses, but where could they be sent? Available places for rheumatic children were already filled and even had long waiting lists. Therefore, it often happened that while these patients were waiting their turn for suitable placement they were sent home despite the fact they were sick children who should have been kept under medical supervision.

Not only was there a lack of beds for these patients when they were ready for discharge from the acute hospital, but also there was a need for developing methods of preventing respiratory infections which so often precipitate recurrent rheumatic infection during recovery from an acute attack. But how should a child be protected from colds? It was exactly that problem we sought to explore. It appeared a reasonable venture to take children who were in the convalescent stage, place them in a more or less isolated colony in an open-air environment following the general principles of a tuberculosis regime. That as far as we know, had not been adequately tried out as a method of care for the rheumatic child. About this time there was considerable enthusiasm for sending children south to a warm, balmy atmosphere where there was comparatively little rheumatic fever in the native population. We proposed just the reverse, placing them out-of-doors in the rigorous atmosphere of New England, in an attempt to build up their resistance.

During the first year only children recently recovered from active infection were admitted in order to test the procedure with a cautious beginning. This was thoroughly successful and so subsequently any children needing convalescent care were admitted whether with or without heart disease, with or without active infection. Since we first opened the Sanatorium to rheumatic fever, up until November 1944, there were 201 children admitted. Approximately two-thirds of them were admitted in the active phase of rheumatic infection; about 50% had evidence of heart disease. Patients with heart disease were arbitrarily divided into two categories; (1) mild or moderate, and (2) severe. A history of pericarditis or congestive failure, which may be considered as two of the most severe manifestations of rheumatic heart disease, were chosen as the criteria for classifying a child as having had severe heart disease. No patient was admitted who, at the time of admission, had evidence of either pericarditis or congestive failure, but 8% had been through these serious episodes which are usually associated with an unfavorable prognosis. An attempt was made to select patients who were in the early stages of rheumatic infection, feeling that more could be done for such patients than those with far advanced heart disease.

One of the most conspicuous features of the plan of care developed at Sharon has been keeping the

continued on next page

* Presented at the Annual Dinner of the Children's Heart Association of Rhode Island, at Providence, January 2, 1946.

children in open-air wards both winter and summer. No child with even severe heart disease suffered in any way from being kept outdoors on the coldest days. The Sanatorium which had been a tuberculosis sanatorium, was closed to tuberculosis and turned over entirely to rheumatic fever. A certain amount of remodeling had to be done in order to have open-air porches with the exposure to the South. Glass partitions were set up on these porches to separate the children as a further precaution against cross-infection.

The customary methods of symptomatic treatment were used. Salicylates were given for the relief of arthritic pains, and occasionally for a possible beneficial effect on pericardial or pleural effusions. As the symptoms subsided, the salicylates were gradually reduced and then omitted altogether in order to avoid masking any evidence of active infection. Symptoms and signs of active rheumatic fever were the criteria to determine how long a patient should be confined to bed. These are now generally accepted and may be enumerated as follows: inflammation or pain in one or more joints; chorea; erythema marginata; subcutaneous nodules; evidence of cardiac decompensation; progressive cardiac damage, such as the development of aortic regurgitation in a patient who has had only mitral involvement; pneumonitis; percarditis; rectal temperature over 100° F; elevation of pulse (the sleeping pulse has been recorded regularly and has been particularly helpful); increase in the leukocyte count; increase in the erythrocyte sedimentation rate; anemia; prolongation of the PR interval of the electrocardiogram.

We have followed the generally accepted and fundamental principle of enforcing complete bed rest until there is no evidence of active infection as indicated by the criteria enumerated above. When there were no further signs or symptoms of active infection, the patients were allowed a carefully regulated program of increasing activity, up out of bed and sitting in a chair, walking to the bathroom, out of bed for a period of time which was usually increased one hour a week, participating in the occupational therapy and school groups and then allowed out in the yard, generally after reaching the point of being out of bed six hours daily. This schedule was individualized according to the duration and severity of the disease. A child with no heart disease was allowed to progress more rapidly than a child who had suffered considerable cardiac damage or had been in bed for a longer time.

When patients reached the point of being up all day, they were placed on a full ambulatory regime which included a rest period before and after meals. The cardiac patients were purposely allowed to mix with the non-cardiacs, and emphasis was placed on an attempt to prevent the cardiacs from developing the psychology of invalidism. No matter how much valvular damage or cardiac enlargement was present, the patient was allowed as much activity as was possible within the limit of dyspnea which was found to be the best guide, easily understood by the patient and by those responsible for his supervision while at the Sanatorium or later after discharge. This policy allowed a much greater degree of freedom than is often recommended. It is based on the observation that it is not so much the degree of cardiac damage that calls for restriction of activity, as it is the presence or absence of active infection.

From the outset, the plan of management has been built upon detailed and persistent efforts to prevent the introduction of respiratory infections or the spread of hemolytic streptococci from the throat of one patient to the throat of another. In the first place, the group has been kept as a pure rheumatic fever colony thus avoiding the possible dangers of a general convalescent home where varied chronic infections may introduce streptococci either directly by spread from one patient to another, or indirectly by carriers among the personnel. No visitors with any infection were allowed All visitors were urged to refrain from kissing or bending over the children.

Most of the patients remained at the Sanatorium for long enough periods to constitute a significant part of their devolopmental life; the average stay was eight months. Therefore, facilities for the educational, social and recreational rehabilitation of the patients were considered essential.

School teachers were employed to give individual instruction to the bed patients and group instruction to the ambulatory patients. In nearly every case the child was able to return to the proper school class upon discharge from the Sanatorium.

Medically trained social service workers, preferably experienced in the problems of rheumatic fever, are an essential part of any rheumatic program. Before admission to the Sanatorium a social investigation of the patient's home was made and throughout the period of stay close contact was maintained with the parents. The parents were allowed to visit once a week and with the help of the social worker received consistent and friendly education in the significant features of rheumatic fever, the danger of respiratory infections and the methods of preventing them, the importance of proper hygiene, avoiding over-crowded, overheated sleeping quarters, and the proper management of heart disease. Thus while the child was at the Sanatorium, his home was being prepared to receive him when he was well enough to return. After discharge the social service worker maintained contact with the family so that a very satisfactory follow-up record was possible.

A full-time, trained occupational therapist provided supervised constructive handiwork for all patients whether ambulatory or confined to bed. Recreational programs were arranged for the ambulatory children without which any group of children will turn to mischief.

Whenever possible all patients were kept at the Sanatorium for at least two months after they reached the point of having full ambulatory activity, or as full as the cardiac status allowed. This period was intended to restore them to robust health before returning home and to prevent the rheumatic recurrences which are so apt to occur following discharge from a hospital or convalescent home.

Rheumatic children are apt to have extensive dental caries. It is uncertain whether this fact has any direct relation to rheumatic fever itself; however, dental care was included as a part of the general care of the patient. Dental facilities were provided in the Sanatorium building so that before discharge the mouth of each patient was clean and free from caries.

When the child was ready for discharge from the Sanatorium he was given an appointment to return to the referring agency or physician. Since most of the patients originated in the rheumatic fever clinic of the Children's Hospital, they returned to this clinic. At the age of twelve years, the upper age limit for the Children's Hospital, they were discharged to the care of an adult clinic or a private physician. A large proportion of them were followed in the cardiac clinic of the Massachusetts General Hospital.

Emphasis has been placed on the incidence of recurrences of rheumatic infection occurring while at the Sanatorium and also following discharge. This may be taken as one of the most valuable criteria in judging any plan of care for rheumatic children. As stated at the outset, one of the main considerations in establishing this group of children in an open-air sanatorium was an attempt to prevent respiratory infection and recurrent rheumatic infection during the period of convalescence. Eight patients (4.8%) had a recurrence while at the Sanatorium. Following discharge, during the periods of follow-up, there were 38 (24.4%) recurrences. There were no fatalities at the Sanatorium. Any patient who had a fulminating, progressive disease or who had developed severe congestive failure was returned to the Children's Hospital where more appropriate attention could be given to a critically sick child. Without attempting at this time an analysis of these figures in comparison with other institutions, it may be said that the incidence of recurrence and the mortality compare very favorably with results for any comparable group.

In the light of these results, certain factors involved in convalescent care may be discussed with particular reference to the child's own home, foster home, sanatorium or convalescent home.

There are obvious advantages to having a child kept in his own home environment during a prolonged period of convalescent care, the most important of which is maintaining his position as an integral member of the family. The extent to which this plan of management is desirable involves such factors as the size of the family, the economic status, the provision of a separate room, adequate nursing care, and the availability of home teaching. Since most of the children developing rheumatic fever come from the lower economic social levels, home care cannot always provide these resources.

Foster home care in certain areas has been developed as a suitable substitute for home care. It is important, however, to bear in mind that if foster home care is to be properly defined, the number of children placed in any one home should not exceed in numbers the limits of an ordinary family. When a foster home takes in ten to fifteen children, particularly if they are placed together in a crowded room or ward, it ceases to be a foster home and should more suitable be classified as a convalescent home.

Any satisfactory plan of management for convalescent care of rheumatic children must take into consideration two major factors: (1) suitable medical care and (2) attention to the development of the child's whole personality during the period of his convalescence. Suitable medical care involves regular attendance by physicians familiar with the characteristics of the disease, adequate nursing care given by personnel also familiar with the peculiarities of rheumatic fever, facilities for routine laboratory procedures including sedimentation rate determinations, provision for the isolation of any patient developing respiratory or other communicable disease, and dental care preferably within the institution. Frequently the periods of the time during which these patients must remain under close medical supervision stretch into many months or even years, constituting a considerable proportion of the child's life. Training and education can not be neglected during these periods. The children must be taught so that he may eventually rejoin his own age group at school; he should be trained in constructive habits, and, for those with severe cardiac damage, taught to remain within the limits of his cardiac reserve. Considering the fact that most rheumatic children come from poor families in crowded quarters of the community, there are very few homes that can afford these essential attributes of adequate care. Even in homes where all these necessary services may

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HEMANGIOMAS

Should treatment be expectant or active?

F. RONCHESE, M.D.

The author. *Francesco Ronchese, M.D., Dermatologist, Rhode Island and C. V. Chapin Hospital, Diplomat A. B. D. S., Instructor in Dermatology, Boston University.*

SHOULD hemangiomas in infants be given active treatment or not? This is a question frequently raised in response to (1) case reports illustrating the spontaneous disappearance of infantile hemangiomas or to (2) articles advising against any form of therapy because of their spontaneous regression within 5 years. Consequently, advocates of active therapy are even under accusation of operating unnecessarily and dangerously.

That vascular tumors may disappear spontaneously is proved beyond a doubt in the papers of Lister[3], Hopkins[1], Watson and McCarthy[4].



Fig. 1 — (left) A doughy, doughnut-shaped, flesh colored tumor below the knee of a 2 weeks old male infant. Because of the location, age and deferred diagnosis, expectant therapy was decided. Six months later the tumor was completely gone leaving only a slightly wrinkled surface, (right) the same infant's leg at 18 months of age.

The nature of this tumor remains a puzzle, but what tumor, other than a vascular one, could have disappeared spontaneously?

The case illustrated in figure 1 is a further demonstration of this fact. The disappearance may be tentatively explained as a sudden severance of blood supply to that area. It is evident, however, that not "every such tumor" disappears spontaneously, otherwise none at all would be seen in the adult. Moreover, according to my tabulation, the percentage of hemangiomas noted in the adult is far from small.

Everybody knows that warts may disappear spontaneously overnight, that psoriasis may disappear suddenly without treatment, that the infant may outgrow his atopic eczema. The bald spots of alopecia areata may not fill up according to the general rule within a few months. However, who can foresee which warts, psoriasis, or atopic eczema will disappear in later years and which will not; which case of alopecia areata will persist indefinitely or turn to alopecia totalis?

One reason for the small number of hemangiomas seen in adults may be that the great majority of them receive treatment in earlier years particularly in countries providing adequate care of their children. Following out this argument, in countries with fewer clinical facilities more hemangiomas should be seen in adults*.

Since, in my own experience, I have treated, or seen treated, practically all of the infantile hemangiomas, I had no personal recollection of any incidence of spontaneous disappearance. However, on investigating the records of 347 hemangiomas in children under 3 years of age, I found 10 cases in which no treatment had been administered. Unfortunately only 1 of these patients could be reached

*Dr. Reiss of New York, with 19 years experience in China, informs me that he has not noticed any difference in the number of hemangiomas in adults in that country.

continued on page 660



Fig. 2—Strawberry naevi suitable for expectant therapy because of size and location. If they have not disappeared after 5 years they can be easily removed by surgery.



Fig. 3—Cavernous naevi unsuitable for 5 years expectant therapy because of facial location. (below) Good result after insertion of 2—0.25 millicuries radon implants.



Fig. 4—Cavernous hemangioma before and after insertion of 4—0.25 millicuries radon implants. No radiation sequelae.

Should this hemangioma fail to disappear spontaneously, it will take a very skilled plastic surgeon to correct the deformity.



Fig. 5—Cavernous hemangioma at 6 weeks of age and again at 12 years of age, after treatment with surface radium (50 milligrammes tube, 1 cm from skin, 3 hours, 10 exposures at 8 weeks intervals). The lip appears perfectly normal.

However, according to Lister, the possibility always exists that the therapy has nothing to do with the cure.



Fig. 6—Cavernous and strawberry naevi that are particularly unsuitable for expectant therapy because of their small size and facial location.

Why wait 5 years for spontaneous disappearance, when one or two, properly done, carbon dioxide applications will effect a cure in a few weeks with little (bottom left) or no trace at all (bottom right)?

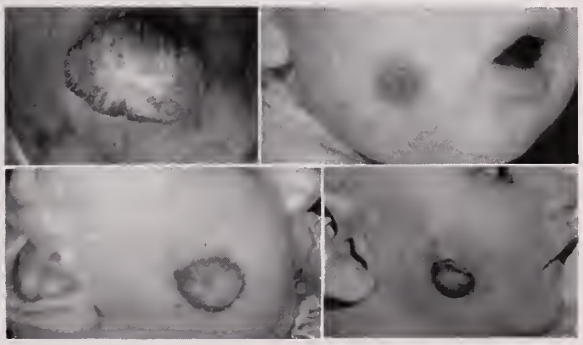


Fig. 7—Partial healing of cavernous hemangiomas after rupture and secondary infection. This therapy, provided by nature, is easier to explain than the spontaneous disappearance without rupture.

A disfiguring location contra-indicating expectant therapy.

for follow-up; in his case a hemangioma of the shoulder had disappeared. But then, on further investigation among other patients of mine and their friends I found 6 cases of spontaneous regression or disappearance, the information being furnished by the mothers.

It is now my intention to leave untreated all hemangiomas located on areas usually covered by clothes or bathing suits, or in other areas when they may be surgically removed later, should they fail to disappear spontaneously, unless parents insist on treatment.

The question of whether or not to treat hemangiomas is particularly disturbing to the dermatologist who is called on to decide what to do. I am sure that no one would choose the hard way.

Lister[3] was the first to make a systematic study of this subject. He made an extensive survey of the literature and then cited his own 7 years of experience with 77 children and 93 naevi. All of these naevi disappeared within 5 years, without treatment.

To this excellent paper, however, some exceptions may be taken. For instance, strawberry naevi are considered synonymous with cavernous nevi. In our textbooks strawberry naevi are described as superficial vascular naevi, usually small and sharply outlined, always slightly elevated. The suggestion of lobulation produces the appearance of a strawberry (fig. 2 and 9).

Cavernous naevi, on the other hand, are described as of any size-pin head, pea, silver dollar, palm, etc. — and as deep, spongy and cavernous (fig. 3-4-5-9-11).

Moreover, the distinction Lister makes between rapidly growing and non-rapidly growing tumors as a prognostic sign influencing the decision for or against treatment, is puzzling. Quite paradoxically, the rapidly-growing are those expected to disappear spontaneously; treatment was recommended for the not-rapidly-growing. In my experience I have never been confronted with such a problem, nor have I heard of it. All infantile hemangiomas appeared at birth or soon after, grew to various sizes, but usually did not progress after the first

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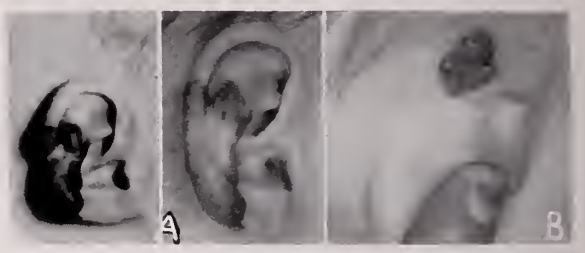


Fig. 8—(A) Cavernous hemangioma of the auricle in a baby girl. Surface radium (50 milligramms tube, 1 cm from skin, 3 hours, 4 exposures at 8 weeks intervals) improved the condition considerably. Since in adult life it would be concealed by the patient's hair, this might be considered a case suitable for expectant therapy. However, should spontaneous disappearance fail to occur, a plastic surgeon would have to make a new ear.

(B) This boy's hemangioma would be suitable for expectant therapy. His sister, now aged four, had 3 small hemangiomas which disappeared spontaneously. However, in this boy no long hair will cover the lesion, it may be damaged during hair-cutting, and interfere with glasses if they must be worn. One, or perhaps two, carbon dioxide snow treatments takes care of such a case in a few weeks. It would be nonsense to wait 5 years for a spontaneous disappearance.



Fig. 9—A sample of hemangiomas that did not disappear.

(A) A naevus flammeous of the scalp turning a cavernous, easily treated by dessication. (B) A typical strawberry naevus on the thigh of a 16 year old girl. A considerable deformity for a girl, unsatisfactorily treated with carbon dioxide snow and sclerosing fluids. A big problem for the plastic surgeon. (C) A strawberry and cavernous hemangioma of the cheek satisfactorily treated by dessication.

(D) A mixture of flammeous, strawberry and cavernous hemangiomas of the nose about which the adviser of expectant therapy cannot brag.

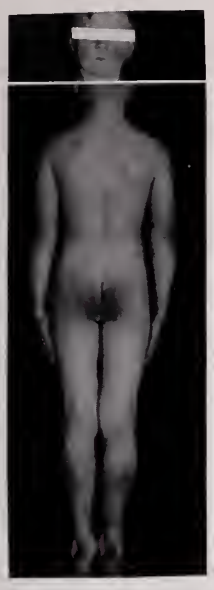


Fig. 10—A very rare vascular anomaly. Congenital, symmetrical, superficial capillary telangectases.

TABLE I
Hemangiomas observed in the last 15 years

	under 3 years	from 3 to 12	over 12
R. I. Hosp. Skin O.P.D.	49	3	2
R. I. Hosp. Tumor Clinic	78	13	36
In my office	220		16
Total	347	16	54

The adult cases of the Tumor Clinic include 1 hemangioma of muscle of arm, 5 of tongue, 1 of palate and 5 typical strawberry. Not included among the non-disappearing are the very common spider naevi, the frequently seen port wine-like hemangioma of palms and soles, known as "red palms" or Lane's disease, connected with several internal diseases but nothing more than a naevus, and the very rare congenital symmetrical superficial capillary telangectases (fig. 10).

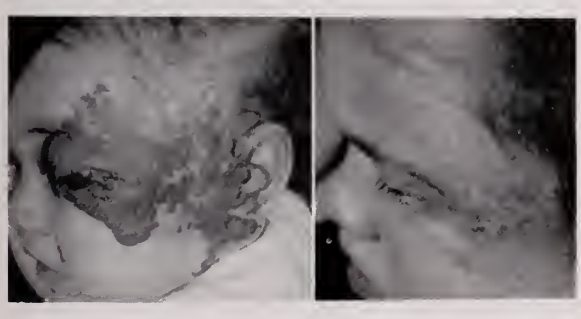


Fig. 11—No dermatologist would be enthusiastic about assuming responsibility for this case. In a discussion of spontaneous disappearance of infantile hemangiomas (1) a similar case was described which disappeared completely without treatment.

This case received surface radium (with a brass shield on the eyeball, although the cornea is known not to be radium sensitive [McKee]), carbon dioxide snow and sclerosing injections. There is now considerable scarring but no defect in appearance or function of the eye.

year and all were suitable for either active or expectant treatment.

The main point of the subject is that "not all" hemangiomas disappear spontaneously and the decision for or against, is to be based on the size and location of the tumor.

Small ones, located, for instance on the head (fig. 6) very disfiguring, but at the same time easily, quickly and satisfactorily treated, should receive treatment. There is no reason to let the parents suffer while waiting the 5 years and take a chance, even if a small one, of a permanent disfigurement.

Those located in areas covered, for instance, by a bathing suit, or hair (fig. 2) and easily treated surgically later, should they not disappear spontaneously, could be left untreated.

Text books of dermatology discuss the treatment of hemangiomas but barely mention spontaneous disappearance. While this implies that authorities prefer active to expectant therapy, the latter should be discussed more adequately and more comprehensive detailed directions given for the management of individual cases.

Summary

The question of treating or not treating infantile hemangiomas, in view of the fact that the majority of them disappear spontaneously, is reviewed and discussed.

Because not all hemangiomas disappear, as proved by their occurrence in adult life, and because with proper treatment the risk involved is very small and the sequelae inconsequential, it is advisable to treat the majority of them, leaving untreated only those which, for size and location, are suitable for later surgical removal, should they not disappear.

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170 Waterman St., Providence 6, R. I.

DIETHYLSTILBESTROL IN THE PREVENTION OF ORCHITIS FOLLOWING MUMPS

JACK SAVRAN, M.D.

The Author, *Jack Savran, M.D., of Providence, Junior Surgeon, Homeopathic Hospital.*

It was the writer's privilege to observe and study a sizable series of cases of adult mumps while on active duty with the Army. It became increasingly apparent that mumps was one of the most common of the contagious diseases in the Army; the most frequent complication of mumps being orchitis with an incidence of between 16 per cent and 30 per cent. The seriousness of orchitis can well be appreciated when one recalls that about 50 per cent of testicles so involved undergo atrophy. An attempt was made to prevent the occurrence of this unfortunate and debilitating complication.

It has been shown that testicular activity may be depressed by the administration of diethylstilbestrol. The incidence of orchitis is low in pre-adolescents with mumps. The writer postulated that this low incidence in pre-adolescents was due to minimal testicular activity and attempted to simulate this state by the administration of diethylstilbestrol. This was carried out in 77 patients ranging from 18 to 34 years of age. No toxic symptoms or side effects were observed in this series which could be attributed to diethylstilbestrol.

Method

The first patients to be treated in this manner received one milligram of diethylstilbestrol three times a day for five days. Three patients of this group developed orchitis and they comprise the only failures in this series of 77 cases. It was felt that perhaps the failures were due to the fact that the dosage was inadequate. Consequently, the dosage was changed to provide each patient with four milligrams a day for seven days.

Since the institution of the increased dose, there were no cases of orchitis except in patients who were admitted to the hospital with the diagnosis of orchitis.

The routine treatment for mumps varied from that commonly employed only by the use of diethylstilbestrol. It consisted of the following measures:

1. Bed rest with lavatory privileges for six or seven days, depending on the extent of parotid or submaxillary swelling.
2. Aspirin, grain ten, for pain when necessary.
3. Soft diet for the first two or three days.
4. Fluids freely.
5. Diethylstilbestrol, one milligram four times a day, for the first seven days. Regardless of the time of admission, the patient received the full dose for that day.

Owing to a temporary shortage of diethylstilbestrol, therapy was interrupted in 17 patients with the result that five cases of orchitis developed. These patients received none of the drug for an average period of 2½ days. These patients were omitted from the series and their data are shown in Table II.

We observed 168 patients who did not receive diethylstilbestrol. The incidence of orchitis in relation to time was broken down into two main groups:

1. Those patients who were admitted to the hospital with orchitis or developed orchitis within the first 24 hours after hospitalization, i.e. "Admission Orchitis."
2. Those cases which developed orchitis in the hospital after the initial 24-hour interval, i.e. "Hospital Orchitis."
   a. One case was classified as "doubtful" since the patient complained of pain in the right testis associated with tenderness upon admission to the hospital. He subsequently developed an orchitis on the left side.

TABLE I

Untreated	*Total Cases*	*% of Orchitis*	*Treated with Diethylstilbestrol*	*Total Cases*	*% of Orchitis*
	168	25.5		77	18.2
1. Admission Orchitis	15	8.9	1. Admission Orchitis	10	13.0
2. Hospital Orchitis	28	16.6	2. Hospital Orchitis	3	3.9
			2. (a) Doubtful type of Orchitis	1	1.3

TABLE II

Treatment with Diethylstilbestrol Interrupted

	Total Cases	*% of Orchitis*
	17	53.3
1. Admission Orchitis	4	23.5
2. Hospital Orchitis	5	29.8

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WATERHOUSE FRIDERICHSEN SYNDROME

LEWIS ABRAMSON, M.D. AND FRANK MAYNER, M.D.

The Authors: *Lewis Abramson, M.D., Physician, Medical Service, and Frank Mayner, M.D., Pathologist, of the Newport Hospital, Newport, Rhode Island.*

THE Waterhouse Friderichsen Syndrome is a rather rare condition and up to the present time there are only a few more than one hundred reported cases.

Lindsay, Rice, Selinger and Robins[1], Cary[2], Michael and Jacobus[3], Levinson[4], Kunstadter[5], McLean and Caffey[6], McNamara and Cornell[7], Drummond and Took[8], Aegerter[9], Kwedar[10], and Monfort and Mehrling[11] are recent authors who review the literature, give the history, clinical findings and pathology of the Waterhouse Friderichsen syndrome.

The usual clinical picture is that of a sudden onset in an otherwise normal child, of headache, malaise, anorexia, elevation of temperature, vomiting and diarrhea. Ten to twelve hours later marked cyanosis of the skin develops, followed shortly by petechial mottling action of the skin which may be cold. Convulsions, weak, irregular heart and peripheral collapse occur usually within forty-eight hours. The age is usually between six months and nine years, with 70 per cent under two years. The number of male and female patients is the same. Smears taken from the petechial hemorrhages, stained with Gram's Stain, may reveal gram negative intracellular diplococci. The blood count usually shows a polymorphonuclear leucocytosis. The spinal fluid examination is not consistent. The condition is invariably fatal, although Carey[2] reports a case with recovery. Treatment consists of the administration of the suphonamides, epinephrin and desoxycorticosterone. The etiological agent appears to be an overwhelming septicemia of either meningococcus (most common), pneumococcus, staphylococcus, streptococcus, hemophilus influenza and Neissera flavus. The pathology consists of extensive bilateral, adrenal hemorrhage, probably due to either the action of a toxin or venous thrombosis.

The authors had the opportunity of observing the following case at the Newport Hospital:

A twelve year old native born girl was first taken ill at school about noon the day before admission. She had some moderate headache and felt weak and nauseated. She came home alone and went to bed. About four p. m. she began to vomit and she looked greenish in color. Vomiting was not projectile and contained some particles of food but no blood or unusual material.

She continued to vomit and to complain of severe weakness but the headache was not very great. It was felt she might be observed for a while and the orders were nothing by mouth.

At eleven p. m. she had a fine rash which was described as something like scarlet fever.

At four a. m. the family called to say they thought she was dying. She was hospitalized at once.

At hospital oxygen was started and she was given a plasma infusion. At that time her skin was covered with purple petechiae and she was not responsive. She was in circulatory collapse and looked moribund. She died shortly after.

Past history revealed that she was a congenital quadriplegic and had attained sixth grade parochial school with difficulty. Her posture was always poor and dental caries was pronounced. A blood phosphorus study was normal. She had had no serious illnesses.

Physical examination showed no stiff neck and when done at hospital she was moribund. Heart sounds were of fair quality and there were no murmurs. Pulse rate was 150. Temperature was 106°. Respirations were 60 and shallow.

At death she was in complete peripheral vascular collapse.

An autopsy was performed one hour post mortem and only the positive findings will be mentioned.

External Examination: The body is that of a developing, white girl, appearing approximately the stated age of eleven years. Slight shortening of the left leg is present. The skin throughout the body, including the face, contains many petechial and other larger confluent hemorrhages. Several of these are cut into; a smear made and stained with the Gram's Stain shows occasional polymorphonuclear leucocytes, containing intra-

continued on next page

cellular Gram-negative biscuit-shaped diplococci.

Adrenal glands: Both adrenal glands are normal in size. They are very dark red in color and completely hemorrhagic and necrotic. No viable adrenal tissue is visible.

Brain: The usual incision is made and a segment of calvarium is removed. The sub-arachnoid areas are slightly dull in appearance and contain a milky-like fluid which when smeared on a slide shows the presence of many polymorphonuclear leucocytes but no organisms can be found.

Microscopic Findings

Adrenal glands: Sections show complete necrosis and marked degree of hemorrhage due to extravasated red blood cells throughout all the sections, practically no viable adrenal tissue is left including cortex and medullary zones. The hemorrhage likewise extends beyond the capsule of the adrenal gland.

Brain: The meninges are thickened and infiltrated with many loucocytes, the majority of which consist of polymorphonuclear leucocytes. A rare mononuclear cell is likewise present. In the area of the fourth ventricle through the medulla oblongata, the blood vessels just beneath the ependyma likewise show peri-vascular infiltration. The gray and white matter is microscopically negative.

The liver, spleen and kidney show slight congestion.

Anatomical Findings

1. Hemorrhage of adrenal glands, bilateral (so-called Waterhouse-Friderichsen syndrome).
2. Meningococcic meningitis.
3. Shortening of the left leg.

Summary

The clinical and pathological features of Waterhouse-Friderichsen syndrome have been reviewed and one more case has been added to the literature.

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CONVALESCENT CARE OF RHEUMATIC FEVER

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be provided, the advantages of keeping the child in his own home should be balanced against the advantages of group management where the child is not singled out as an invalid but rather is more apt to consider himself no different from his fellows. At home he looks through his window and sees his friends going to school; when one of a group his friends are in the adjoining beds.

In conclusion it is fair to state that the results of this experience in the convalescent management of children with rheumatic fever demonstrate that an open-air sanatorium may be not only satisfactory but advantageous. When due consideration is given to the principles discussed about, it provides relative freedom from recurrent infection, adequate facilities for medical supervision and training in citizenship for the rheumatic fever child.

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"WITHOUT REFLECTION"

"It is contemplated that this General State Hospital would become the State's leading Medical Center, a center of research, a center available to the medical and nursing professions of the State, whereby members of the medical profession, particularly, could be kept up to date with respect to the rapid development in modern medicine, especially in the fields of bio-chemistry and nutrition.

"Without reflection upon individual members of the medical profession, experience of recent years shows that a center of research and information would be invaluable when such epoch-making drugs as the sulfa drugs and penicillin are developed. I am reliably advised that there was not one single physician in Rhode Island in the beginning, professionally capable to deal with penicillin and its marvelous potentialities. Only a few medical schools today give courses on the all-important subject of scientific dietetics and nutrition. Many doctors engaged in medical practice or attached to hospitals know less about the science of dietetics and nutrition than the professional dietitians in the kitchens of our hospitals."

CLEMENS J. FRANCE, Director, Rhode Island Department of Social Welfare, in his Eleventh Annual Report to the Governor and General Assembly, and to the interested public, submitted July, 1946.

The quoted abstracts from Mr. France's report to the Governor, the General Assembly, and the public generally, noted above, illustrate in clear fashion some of the loose thinking that is allowed to find its way into print in governmental reports. Mr. France has indeed spoken "without reflection". He may envision a General State Hospital at Howard that would constitute, as he says, "a State medical and clinical center, such as for example, the Medical Center established by the Mayo Brothers in Rochester, Minnesota, or the Lahey Clinic and Medical Center in Boston", and we will allow him to dream. Personally, we will settle, for the present at least, for the fulfillment of the recommendations of the non-partisan State Commission on Public Welfare Institutions, made in 1943, that there be a "development in staff, accommodations and equipment which will make this hospital a well-equipped and up-to-date institution capable of providing the best possible care of patients with acute and chronic disease", and that "the staff should be organized as is that of any general hospital with regular services and a group of visiting physicians and surgeons on active duty", thus "to allow the hospital to receive recognition from the American Medical Association and the American College of Surgeons, a fact which will assure a much better group of internes and residents than can otherwise be obtained." When that is done the State Hospital will make the first long step towards reaching comparable high standards of hospital and

continued on next page

medical care now provided in the outstanding private hospitals of the State.

But when Mr. France goes on record with the statement that there *was not one single physician in Rhode Island* in the beginning, *professionally capable to deal with penicillin*, he speaks poorly advised, and with little or no knowledge of the practical application by the physician of the results of scientific research. His implications are far reaching, and they might readily be dismissed on the basis of what is freely asserted is freely denied, were it not for the fact that Mr. France, as a public servant, has neither justification nor authority for his indictment of the medical profession of this State. When he states he speaks "without reflection upon individual members of the medical profession" he very apparently tries to soften his blow at all the doctors.

Since Mr. France cites penicillin as an example he warrants advice on the allocation and clinical use of this drug. Like any new discovery to come out of the research laboratory, penicillin was subject to close control and much selected experimentation before it was allocated to physicians, first for use in the hospital, and later for general use. Not even Mr. France's proposed General State Hospital would have had any freer access to the drug, nor would its staff been in any better position to explain its method of administration or clinical uses, than were the local private hospitals and physicians.

Penicillin from the beginning was under the supervision of the Committee on Chemotherapeutic and Other Agents of the National Research Council under the chairmanship of Dr. Chester S. Keefer of Boston. Carefully controlled clinical studies to investigate the value of Penicillin in various infections were conducted by a large number of accredited investigators under the supervision of this Committee, and the results obtained in this cooperative investigation were collated and analyzed for the information and the education of physicians everywhere.

The original report of the Committee, analyzing 500 cases it had approved for treatment with penicillin, was published in late August, 1943. Earlier in that same month the drug was used at the Rhode Island hospital. And in April, 1944, at the regular scientific meeting of the Providence Medical Association, thirteen Providence physicians presented reports on penicillin-treated cases in four of the hospitals in Providence, for the information of their colleagues.

And all this was done, as Mr. France apparently was not advised, at a time when the National Research Council was releasing very little of the drug, and then only for experimental studies in selected cases. Most of the very limited supply of penicillin went to the armed forces for use in the treatment of battle casualties.

Through scientific medical publications, medical assemblies and hospital staff meetings physicians in general were well acquainted with the clinical uses and administration of the drug by the time it was available in quantity sufficient for the wider allocation of it for civilian illnesses. The same situation prevailed in the case of the sulfa drugs.

When Mr. France discusses diet and nutrition he falls into a parallel error in judgment, for he fails to realize the difference between the need and application of diets as determined by the physician for his patients, and the technical procedures involved in the makeup of the diets as carried out by the professional dietitian.

To paraphrase Mr. France's words, it would appear that some authorities engaged in health and welfare work or attached to governmental social welfare agencies know less about the necessity of long experimental studies and the application of the results of scientific research than the novice social worker in the field.

HARD TO DIGEST

We have often wondered how some of our associates get their vast extent of therapeutic knowledge — so far beyond our own. Really, the answer is simple. They read the Reader's Digest, which we dislike and therefore neglect. The Professor of Therapeutics in this medical school for the multitude is Paul deKruif. Despite his authoritative tone we understand that he is not an M.D.

The last description of Utopian medicine which Dr. deKruif has contributed is an article on Demerol, synthetic substitute for morphine put out by the Winthrop Chemical Co. We will list under our own numbers some of the doctor's statements.

The text for his talk is placed as a heading and reads, . . . [1]"The pain fighting power of Demerol is as miraculous as that of morphine—[2]without the opiates' danger of addiction". [3]He tells of men hurt by a hot beam on their foreheads but not minding it. A man with kidney colic smiled. He no longer minded the pain. A hysterical woman smiled with her labor pains. "I don't seem to mind them. This medicine makes me brave." We gather from the article that having received Demerol all patients are euphoric while still in pain.

[4]In the whole Digest article only two bad effects of Demerol are suggested. It might mask the symptoms of appendicitis and large doses are dangerous; and the latter statement can be truthfully made of practically any drug in the pharmacopeia.

We have before us a booklet on Demerol sent out by the manufacturers. Now it is hard to blame a firm for being enthusiastic about their own products. We expect this in all modern advertising. But consider their restraint on the points taken up

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DIVISION OF MEDICAL SCIENCES

COMMITTEE ON CHEMOTHERAPY

August 23, 1946

Dr. Peter P. Chase
122 Waterman Street
Providence, Rhode Island

Dear Dr. Chase:

I have before me the letter from [illegible] under date of the 9th of August in which the statement was made that a public official in a formal report made the following statement: "I am reliably advised that there was not one single physician in Rhode Island in the beginning, professionally capable to deal with penicillin and its marvelous potentialities".

There never was any question in the minds of the Committee on Chemotherapeutic and Other Agents about sending penicillin to Rhode Island physicians once it became available to our Committee for clinical investigation and at a time when individual physicians in the United States were included in the research program.

According to our records, the first case was treated in August, 1943. This was one month after penicillin had been placed under allocation by the War Production Board and one month after individual physicians throughout the country were included in the research program. The case was that of a patient with osteomyelitis under the care of Dr. Elihu Wing, and according to the report the results were highly successful. To repeat, we never had any doubt concerning the capabilities of Rhode Island physicians in using penicillin under our program.

Sincerely yours

Chester S. Keefer

/s

Chester S. Keefer, M.D.

HARD TO DIGEST

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by our chronicler of miracles. Here are the firm's modest statements . . . [1]The analgesic power of Demerol ranks between morphine and codein. (*most of the profession know that codein is a mighty weak pain killer. Ed.*) [2]It carries considerable less risk of addiction than that inherent in morphine. [3]The incidence of euphoria in presence of pain is about 10%. [4]Where the Digest can find only two moderately adverse effects from the use of the drug the manufacturers frankly admit several; thus: Dizziness is a common side effect. Nausea and vomiting occur sometimes. Extreme weakness, syncope, profuse perspiration may occur. Significant side effects have been noted in 25% of cases.

The Winthrop Chemical Company have issued a frank, proper report on what is presumably a valuable drug. In marked contrast is the sensational Digest article, wickedly designed to delude an ignorant public. Who could be in a better position for an unbiased estimate of Demerol than H. J. Anslinger, Commissioner of Narcotics, Washington, D. C.? These are his conclusions in a letter to the Journal of the American Medical Association.

> ". . . I fear a wave of Demerol addiction if physicians who read this article believe what I consider the reckless and dangerous statements made by deKruif that the drug is free from addiction properties. . . . Had this article been prepared on a strictly scientific basis it would have sounded a strong warning about the danger of addiction. Our files contain numerous cases of addiction involving the use of Demerol. I cannot too strongly warn the members of your Association about the danger of addiction to Demerol."

Meanwhile physicians are already being pestered by patients who feel that their sufferings from arthritis, sick headache, etc., should be alleviated by the "harmless" Demerol.

If the statements made in the magazine article were printed on the label under which the article is sold the Federal government would intervene. But the rule of caveat emptor apparently still holds for "popular articles."

ETHER CENTENNIAL

On October 15, 16 and 17, Boston celebrates the Centennial of the Discovery of Surgical Anesthesia with luncheons and dinners, clinics at the hospitals, orations by notable guests and eulogies on Dr. William Thomas Green Morton; for on October 16, 1846, Dr. Morton first demonstrated the benefit of surgical anesthesia at the Massachusetts General Hospital in Boston. On that day Dr. Morton administered ether by inhalation while Dr. John Collins Warren did an operation for a vascular tumor of the neck. A few days later Morton again administered ether while Dr. Warren did a major operation, a thigh amputation. These were memorable operations because the patients did not cry out with pain, did not struggle against the restraining bands, but slept peacefully while the operation was being performed and awoke to testify that they had felt no pain from the surgeon's knife.

News of this event spread with unparalled rapidity throughout the world; by the end of the year anesthesia was being employed in London, in Paris and elsewhere in Europe; within six months it was known and practiced throughout the civilized world. There could be no doubt that Dr. Morton, by overcoming pain in surgery, had performed an inestimable service to humanity. It was foreordained that this tremendous event should be fittingly commemorated now, and in Boston.

No one can doubt the importance of Morton's successful demonstration of the possibility of painless surgery for if it had failed the use of anesthesia in surgery and in childbirth would have been postponed for years, perhaps forever. But there are many mistaken ideas about what Morton discovered and what he demonstrated. Morton did not discover ether; it was known to the alchemists in medieval times. He was not the first to use ether by inhalation; it was used by Dr. Warren in his routine practice. He was not the first to suggest the possibility of relief of pain; Humphrey Davy had predicted that nitrous oxid might relieve the pain of surgical operations.

Morton did discover that inhalation of ether vapor could render a subject incapable of experiencing pain during a surgical operation and that the patient would safely recover. He found that the ether used must be pure and that the vapor must be diluted with a large proportion of atmospheric air. Morton discovered that pain in surgery could be relieved with safety. He made the revolutionary decision that pain should be relieved and set to work diligently to bring about that desired end.

Others sought to prove that they had used ether for pain relief before Morton demonstrated its practicability and safety, and their claims may well be true. But what state of mind led them to conceal a discovery so obviously needed for the benefit of humanity? They may have failed to appreciate the grandeur of the discovery; they may have been selfishly callous to widespread suffering among other people. William Morton realized the importance of his discovery. He sacrificed fortune, health and life to hasten its universal adoption.

PATRONIZE

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Program of the Fifth Annual Session, Sponsored by the Medical Societies of New England, at Boston, October 30 and 31, 1946

OCTOBER 30

10:00 THE NATURAL COURSE OF HYPERTENSION . . . James Berdley, M.D.
(Johns Hopkins Hospital, Baltimore)

10:30 TIME OF ELECTION FOR ABDOMINAL SURGERY . Edward J. Donovan, M.D.
(College of Physicians and Surgeons, New York)

11:15 PART I. 200 Obstetrical Consultations in Private Practice—A review of the commoner complications which both the general practitioner and the obstetrician confront.
Nicholson J. Eastman, M.D.
(School of Medicine, Johns Hopkins University)

11:45 TROPICAL DISEASES . . . . . Joseph Hayman, M.D.
(School of Medicine, Western Reserve University, Cleveland)

12:15 (Luncheon meeting at Hotel Bradford)
MEDICAL ASPECT OF CARE OF CANADIAN VETERANS, W. P. Warner, M.D.
(Director General, Department of Veterans Affairs, Canada)

2:00 THE POSSIBLE ROLE OF A COMMUNITY HOSPITAL IN POSTGRADUATE TRAINING . . . . . Frank Glenn, M.D.
(Cornell University Medical College)

2:30 TETANUS TOXOID . . . . . Yale Kneeland, M.D.
(College of Physicians and Surgeons, New York)

3:00 THE ACTION AND USE OF THE NEWER DIGITALIS PREPARATIONS
Harry Gold, M.D.
(Cornell University Medical School)

3:45 BLOOD BANK . . . . . Sir Lionel E. H. Whitby
(Regius Professor of Physic, Cambridge, England)

4:15 THE TREATMENT OF SYPHILIS . . . . . Joseph E. Moore, M.D.
(School of Medicine, Johns Hopkins University)

8:00 (Dinner)
VETERANS ADMINISTRATION ORGANIZATION AND FUTURE PLANS
Major General Paul R. Hawley, MC
(Chief, Medical Division, U. S. Veterans Administration)

continued on page 672

PALATABILITY AND NUTRITION FACTORS of Campbell's STRAINED BABY SOUPS



Q. What is the importance of palatability?

A. A leading pediatrician has pointed out that even in the early months of life infants are able to detect minute differences in flavor. The appealing palatability of Campbell's Strained Baby Soups is, therefore, an advantage. It should further be pointed out that all the "tastes" in these soups are the wholly natural ones of the meats, vegetables and cereals used.

Q. Why are the different ingredients selected?

A. Campbell's Strained Baby Soups are planned to provide a balance in nutrients to supplement the daily milk diet. Since it takes many different foods to supply the approximately 40 nutrients needed for infant development and energy, we use vegetables and a cereal in preparing each of the four meat soups. Flavor is improved, too. For instance, liver alone has too strong a taste for some babies, but blended with vegetables, palatability is enhanced. It should also be noted that these soups are intended for use as early in normal infancy as any other strained baby foods.

Q. What measures are taken to conserve food constituents?

A. In preparing these Baby Soups, Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins.

A comprehensive analysis of each soup may be had upon request to Campbell Soup Company, Camden, New Jersey.

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OCTOBER 31 — Morning Session

9:00 WHAT CAN X-RAY THERAPY DO FOR MALIGNANT CONDITIONS
Eugene Pendergass, M.D.
(School of Medicine, University of Pennsylvania)

9:30 EARLY RECOGNITION OF CARCINOMA IN THE UTERUS
Lewis C. Scheffey, M.D.
(Jefferson Hospital, Philadelphia)

10:00 PART II. 200 Obstetrical Consultations in Private Practice
Nicholson J. Eastman, M.D.

10:45 ANTIBIOTICS . . . . . Yale Kneeland, M.D.
(College of Physicians and Surgeons, New York)

11:15 GYNECOLOGY IN THE COMMUNITY . . . . . Lewis C. Scheffey, M.D.

11:45 A CRITICAL ANALYSIS OF THROMBOPLEBITIS . . Irving S. Wright, M.D.
(Cornell University Medical College)

12:15 (Luncheon. Hotel Bradford)
INFLUENCE OF GOVERNMENT ON MEDICINE IN ENGLAND
Sir Lionel E. H. Whitby

OCTOBER 31 — Afternoon Session

2:15 THE GENERAL PRACTITIONER LOOKS AT HIS JOB . Donald Clark, M.D.
(Monadnock Community Hospital, Peterborough, N. H.)

2:45 HEPATITIS . . . . . John Paul, M.D.
(School of Medicine, Yale University)

3:30 THE DIAGNOSIS AND TREATMENT OF THE NEURO-VASCULAR SYNDROME OF THE SHOULDER GIRDLE . . . . Irving S. Wright, M.D.

4:00 TYPES AND TREATMENT OF DEAFNESS . . . Alfred T. Lieberman, M.D.
(Johns Hopkins Hospital, Baltimore)



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REFERENCES

Rambar, A. C.; Hardy, L. M. and Fishbein, W. I.: J. Ped. 23:31-38 (July) 1943

Wolf, I. J.: J. Ped., 22:707-718 (June) 1943

Wolf, I. J.: J. Ped. 22:396-117 (April) 1943

Wolf, I. J.: J. Med. Soc. New Jersey, 38:436-440 (Sept.) 1941

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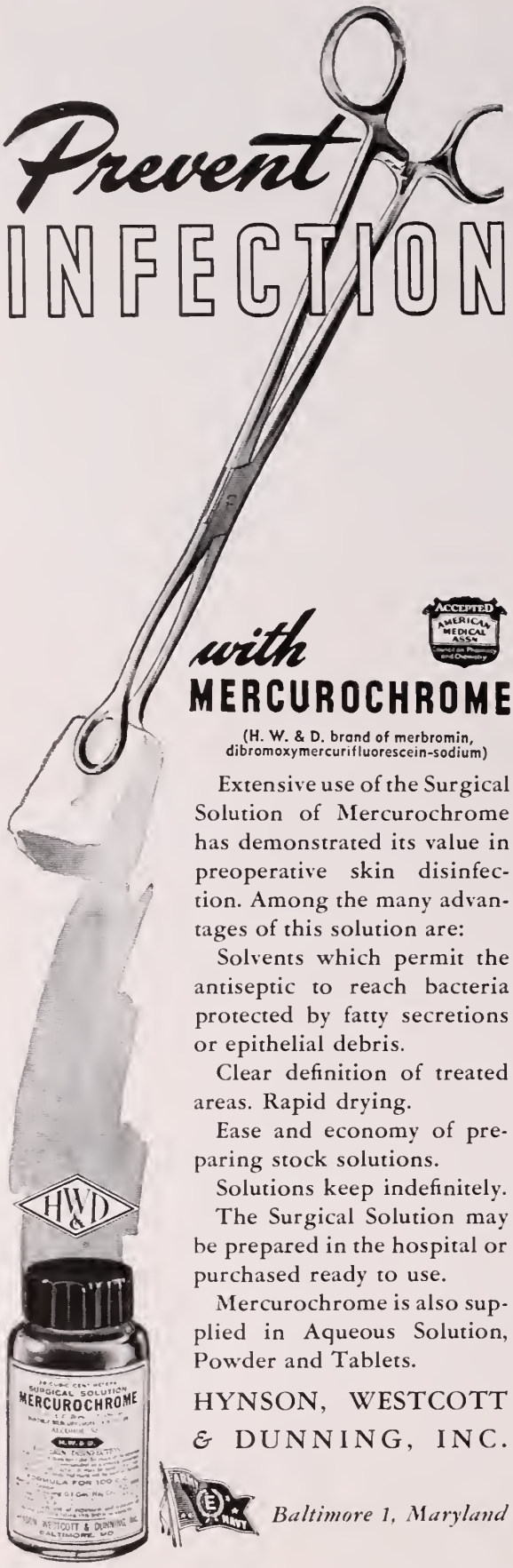
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FROM ONE CARDIAC TO ANOTHER

(The following letter was written to a patient of a Providence physician, and it is published here because of its excellent presentation of a sound philosophical viewpoint for the cardiac patient.

—THE EDITOR)

Dear Mr. .....,

I was greatly disappointed when Dr. ..... and Miss M ..... came and you were not with them, and grieved to learn that you had a cardiac mishap and were still in the hands of the medical men. I welcome you into the great company of the cardiac convalescents (What a name!) and am writing this to assure you that you will find living with a damaged heart not nearly as bad as it seems in the first months of the experience.

On the positive side you will have hereafter a perfect alibi for dodging the things you do not want to do, and a complete excuse for the most flagrant laziness. On the other side you will have to make a rather complete change in your way of life; but the new way will not be at all unpleasant.

I find in my own case that I can no longer row a boat, or run long distance races, but there are many things that I can do that are highly entertaining. When I walk slowly, as I must, I have better opportunity to observe what goes on about me. If I must talk less, it is no doubt to the improvement of what I have to say. If I eat less I enjoy what I can have all the more. I can sit and observe that most interesting of all wild animals, *homo sapiens,* and exert all my abilities trying to figure out why he acts he as does. I can take time to think and write for my own amusement and to read the many things that I have had to leave unread in the past. I am seldom bored. I miss coffee, tobacco and strong drink—tobacco most of all—but they are not the best of life.

So, having adjusted my mental attitude to my present physical capacities I do well enough and I am sure that you will be able to do so.

The old farmer in Michigan who said "Life ain't nothing but three things: filling what's empty, emptying what's full, and scratching what itches" was not far wrong. If we take it one day at the time, and do not fail to enjoy what is there to be enjoyed, we can get a lot out of it. We are only recently out of the tree tops, after all, and don't deserve too much.

You will soon be up and about again. Follow the regimen the physicians lay out for you except where it would make life unendurable. Tell your doctor that you want him to manage things so that you can do what you want to do, and not think that he has done his duty when he tells you that you can't do anything that's any fun.

I shall look forward to seeing you next summer, and in the meanwhile shall burn a candle to St. Anthony of Padua with the request that you will soon be able to return to the kind of life you want to lead.

Sincerely yours,

.....



Truly, this is America . . . the mothers go to school

More than 3,000,000 American mothers, members of some 45,000 Parent-Teacher Associations and similar groups, go back to school to keep on learning the art of living.

YOUR DOCTOR is determined that your children shall have a better start than you did.

Within our time, the health of this nation's young has become the equal concern of its parents, its schools and its medical profession—a profession whose national standards and pediatric advances are held high for the world to see.

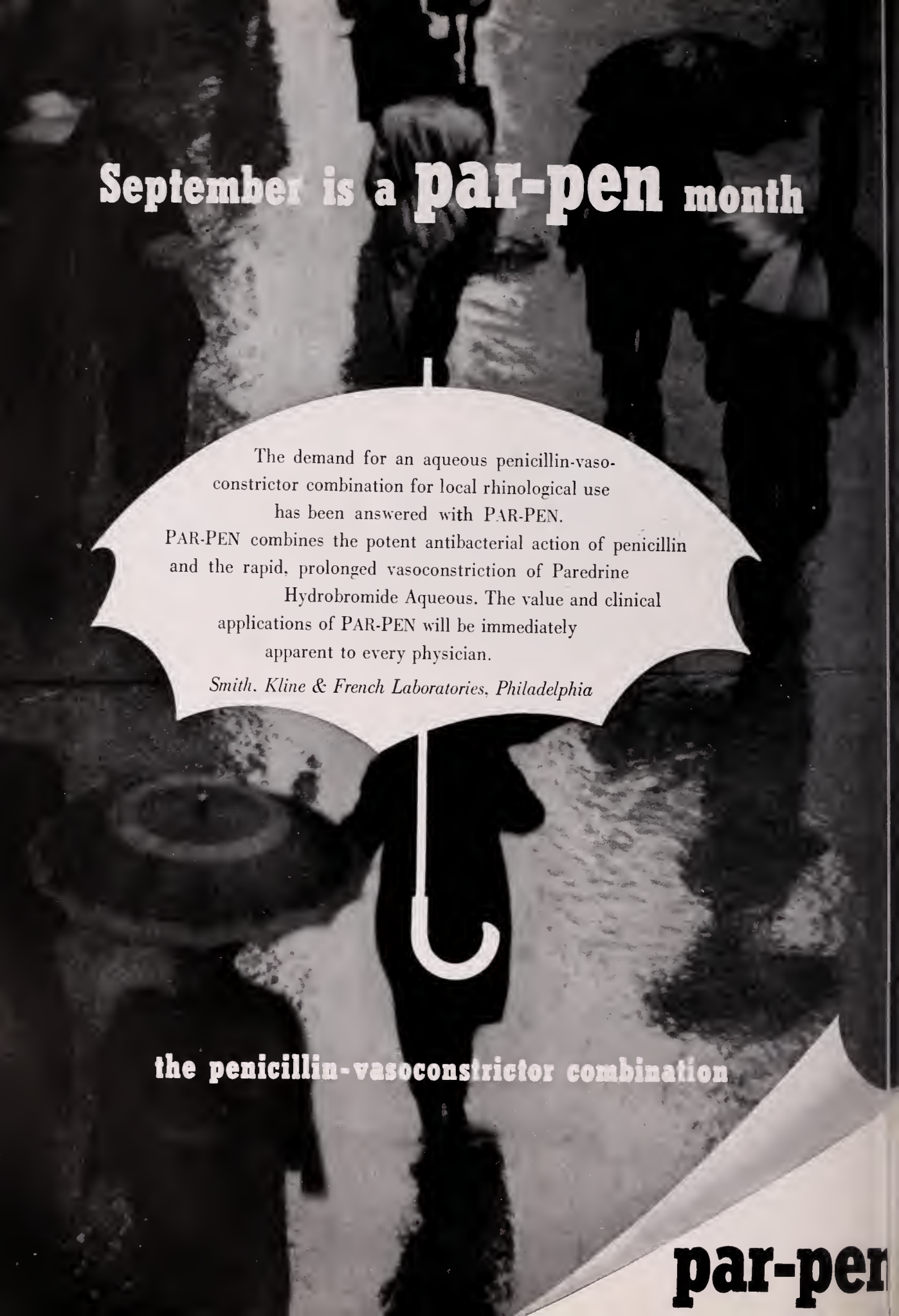
In this achievement, American medicine has smoothed the path by keeping its physicians completely free agents—free to speculate in and develop any of the countless fields encompassed by the art of healing.

Just as American mothers exchange freely their knowledge and methods of their children's problems, so do American physicians exchange their skills and knowledge.

HERE in laboratories located in the typical American community of Summit, New Jersey, medical men of the Ciba organization are spending their lives in pursuit of the newer and finer pharmaceuticals with which the medical profession determinedly advances the treatment of disease. Free to follow their own lines of research, each speeds the work of his associates through open exchange of methods and ideas.



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HOSPITAL CONSTRUCTION ACT

With the signing by the President of the Hospital Survey and Construction Act, an appropriation of 375 million dollars is authorized during the next five years for the construction of hospitals and health centers. Three million dollars is also authorized for State-conducted surveys of need. These must be made preliminary to the granting of Federal funds for construction.

The Act provides latitude for each State to develop its own program of hospital and health center construction, to be administered by State authorities under standards specified by the United States Public Health Service. The Surgeon General will be assisted in establishing standards by a newly created Federal Hospital Council consisting of eight members to be appointed by the Federal Security Administrator.

"This Act sets for the first time a national policy which makes it clear that hospitals in the future must be planned, located and operated in relation to the overall health needs of the people," Thomas Parran, Surgeon General, U. S. Public Health Service said. "This policy, as evolved through the leadership of hospital authorities of the country, is recognition of the integrated role that hospitals and health centers must play in the future. Adequate hospitals, health centers and related physical facilities are the essential workshops, without which it is not possible to provide even a minimum of modern health and medical services."

Any State may initiate action by submitting a request to the Surgeon General for funds to carry out an inventory of existing hospitals, and to prepare a plan for the construction necessary to provide adequate care for all the people. In making the request, the States must designate a single State agency to carry out the survey and planning and must appoint a properly qualified advisory council to consult with the State agency. The proportionate share for each State of the total Federal appropriation for survey and planning will be determined by the populations of the several States. However, Federal funds must be matched by two to one in defraying the survey expenses.

Allotments for the actual construction of facilities will not be made until the State plan based on the survey findings has been approved. Construction allotments to individual States will vary in amount. Population will be one factor, and in addition, the average per capita income will be used in the allotment formula in such a way that States with a lower per capita income, where there is relatively greater need for medical facilities, will receive proportionately larger allotments per capita.

Applications for funds for individual construction projects must be channeled through the designated State agency. Here again, Federal funds may not exceed one-third of the cost of a project. Before any single project is approved by the Surgeon General, sufficient evidence must accompany the building request to show that two-thirds of the total cost of construction is available from other-than-Federal sources, and that financial support is adequate for the maintenance and operation of the institution after completion.



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*Reznikoff, P., and Goebel, W. F.; J. Clin. Investigation 16:547, 1937

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WOONSOCKET HOSPITAL

WOONSOCKET HOSPITAL received its first patient on October 10, 1888. During its first full year of operation, thirty-nine patients were cared for, hardly one third of the number who are now cared for daily. It is interesting to contrast the small beginning with the following figures showing the growth of the hospital in service to the community during the years which ensued:

Fiscal Year	*Number of Patients*	*Average Days' Stay*	*Average Daily Census*	*Patient Days for Year*
1893	97	41.8	11.2	4,088
1903	150	24.8	10.8	3,944
1913	492	20.	27.0	9,855
1923	1365	10.5	39.2	14,312
1933	1997	9.3	51.05	18,633
1943	4743	8.6	112.0	40,801

Many persons speak of "the good old days when we had gas street-lights and low hospital bills." Ward Care in the old days cost $10.00 per week. The average stay of a patient here was 42 days in 1893 at a cost of $60.00. The average days' stay is now about 9 days. At $5.00 per day (Ward Care) this comes to $45.00. Considerable saving there. Of course, costs for extra items are higher because Doctors are using many drugs and supplies which are costlier than in the old days. However how much is it worth to be sick for a few days compared with many days. How much can the bread-winner earn in the days saved from his former sick time. How much is it worth to an employer to have his experienced workman back on the job. How much is it worth to the family to have their sick person back with them quicker and with far more chance for becoming well and useful again. And how much is it worth to have the fine surroundings and well-trained personnel which makes for modern hospital care.

To get back again to Woonsocket Hospital in particular, the buildings are a combination of the old cottage type frame construction hospital and a more modern V-shaped brick building. Previous generations were quite proud of cottage type hospitals. It was believed, probably correctly, that individual care would be more personal in that type hospital as compared to care in the institutional type. With the great increase in number of patients it would have been unwieldy and very costly to have continued the old system. Evidently those responsible liked the cottage type so — when the more modern building was erected it was located in the background. Many persons wonder why the initial view of the entire Woonsocket Hospital brings the cottage type buildings into such prominence.

The buildings are located in the center of the Cass Avenue front. There are 24 acres of land. The property has frontage on three streets. The grounds have many shade trees although the hurricane of 1938 destroyed nearly 150 of these of various kinds. During recent years lawns, shrubbery and trees have been added.

The hospital is rated as a 184 bed institution and is approved by the American College of Surgeons, the American Medical Association and the American Hospital Association. Some of the departments, the Maternity Department in particular, are running considerably above normal. At the present rate the Maternity Department will rank second to the Providence Lying-in Hospital in this state for number of babies born annually. While only a few prospective mothers came for confinement to the hospital prior to 1935 the hospital has recently given a celebration for its 10,000th baby.

The various hospitals outside the Providence—Pawtucket area are doing a splendid job not only in rendering hospital care in the patients' own community but in relieving what would be a tremendous pressure on Providence—Pawtucket hospital facilities. Few persons consider this side of the hospital picture. The hospital load outside the Providence area equals approximately 50% of the Providence area load. Massachusetts and Connecticut residents are cared for in these hospitals to a considerable number.



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MEDICAL LIBRARY NEWS

THE LIBRARIAN of the Rhode Island Medical Society Library announces the recent addition of the following books:

BIOGRAPHY

T. G. Wilson—*Victorian Doctor. Being the Life of Sir William Wilde.* N. Y., 1946.

DIGESTIVE SYSTEM

S. Wolf & G. Wolff—*Human Gastric Function.* N. Y., 1943.

GERIATRICS

E. J. Stieglitz, editor—*Geriatric Medicine.* Phil., 1943.

INFANTILE PARALYSIS

R. H. Berg—*The Challenge of Polio.* N. Y., 1946.

A Bibliography of Infantile Paralysis, 1789-1944. Phil., 1946.

MALADJUSTMENT

L. E. Hewitt & R. L. Jenkins—*Fundamental Patterns of Maladjustment.* 1946.

MEDICINE

F. K. Albrecht—*Modern Management in Clinical Medicine.* Balt., 1946.

J. C. Meakins—*The Practice of Medicine.* 4th ed. St. L., 1944.

H. Rypins—*Medical Licensure Examinations.* Phil., 1945.

METASTASES

M. W. Thewlis—*Metastases.* Charlotte, 1944.

NEUROLOGY AND PSYCHIATRY

F. A. Mettler—*Neuroanatomy.* St. L., 1942.

E. A. Spiegel, editor—*Progress in Neurology and Psychiatry.* N. Y., 1946.

PROCTOLOGY

M. G. Spiesman—*Essentials of Clinical Proctology.* N. Y., 1946.

RESUSCITATION

P. J. Flagg—*The Art of Resuscitation.* N. Y., 1944.

THERAPEUTICS

Transactions of the American Therapeutic Society, 1943-1944.

WAR MEDICINE

The Effect of Bombing on Health and Medical Care in Germany. Wash., 1945.

The Library has received gifts of pamphlets, unbound journals and bound volumes from Doctors Clara and Joseph Smith, the Providence Public Library, Ethicon Suture Laboratories, Eli Lilly Company and Nutrition Research Laboratories.

BOOK REVIEW

IT'S HOW YOU TAKE IT, By G. Colket Caner published by Coward-McCann).

"It's How You Take It" is a concise, helpful, good sense book on "meeting life." The book is simply and clearly written in non-technical language. It fulfills the reader's need to know more about himself.

The author's aim was to produce a book that could be read with interest and profit by late teenagers, but his book should be equally helpful and interesting to adults, particularly to parents and teachers, and to physicians who want a book that they can give to nervously upset patients with confidence that it will not be upsetting and will be helpful. The author is a practicing neurologist and psychiatrist, but the book is one that a well person as well as a nervously upset person can read with profit. It would be an excellent book for a physician's waiting-room, quite like Dr. Walton's "Why Worry," and "Those Nerves," of two decades ago.

CHARLES A. MCDONALD, M.D.

LIBRARY NIGHT HOURS

Starting September 17 the Medical Library will be open every TUESDAY, WEDNESDAY, and THURSDAY EVENING from 7 until 10 p. m., except when a holiday falls on one of these days. The continuance of this service for the benefit of members unable to visit the Library during the day hours will depend upon the use made of the facilities during the next three months.

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We are improving and extending production facilities as rapidly as post-war conditions permit. Meanwhile we are trying to distribute our output as equitably as possible. We hope we shall soon be able to fill every order promptly. Your understanding of our predicament and your continued friendly cooperation will be appreciated.

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THE EXPANDED FEDERAL-STATE VOCATIONAL REHABILITATION PROGRAM*

CHARLES L. NEWBERRY, M.D.

The Author. *Charles L. Newberry, M.D., of Washington, D. C. Senior Surgeon (R) U.S.P.H.S.; Assistant Medical Officer, Office of Vocational Rehabilitation, Federal Security Agency.*

IT IS remarkable that nearly a quarter-century of organized effort had been devoted by the Federal-State program, to the rehabilitation of the vocationally handicapped, before Federal funds became available to the States for the institution of "physical restoration" services. Less than three years have elapsed since it was recognized that the most important determination in the case of a sick or disabled individual is the answer to the question: "Need this man *keep* his defect?"

As co-workers in the field of health we can rejoice in this recognition of the fact that medicine can often do more than palliate and counsel patience; that medicine can quite often remove a handicap, and still more often, can so reduce it as to put a brighter face upon a drab life.

The Medical Social Workers of Rhode Island were kind enough to sponsor my visit here, and I hope that they will not object to my remarks as too much medical, and too little social. I feel, however, that all of us in the healing field are going to do our best work if we consider all of our jobs as extensions of the central arm of all medical services, powered by all members of the healing professions acting as a unit, and expending their co-ordinated energy upon the whole individual, instead of upon his constituent parts.

The physically and mentally handicapped are or have been sick people. Most of them are or have been the patients of physicians. All of them should have the advantage of whatever the healing art can do for them. Many of them still need a fair amount of medical treatment.

Until 1943, this treatment was rarely given as a rehabilitation service. An elaborate system of training and selective placement had to be built around a defect. At best, we ignored curable defects; at worst, the defect, and not the cure was the important thing.

*. Presented at the Annual Meeting of the Rhode Island Medical Social Workers, at Providence, May 15, 1946.

To re-establish medicine as a vital force in rehabilitation calls not only for a different and more constructive type of thinking, but demands a vast amount of medical advice and guidance. We must no longer tenderly nourish curable defects. We must, instead, unremittingly seek their elimination.

Thus, we shall need more than your passive approval and tacit support; we should like to invite you to take a dynamic part in a most fascinating and profitable program. I say profitable advisedly, since it has been our experience that money spent on physical restoration and the other rehabilitation services is repaid many fold, not only in satisfaction and self-respect, but in a measurable cash return, not only to the individual helped, but to the governmental source of that help.

In addition to our medical needs, we are finding that many of the problems in rehabilitation lie in the field of social adjustment and human relationships. We need help in exploring the ways in which the physician, the medical social worker, the psychiatric social worker and the public health nurse, to name only a few, can be brought to bear upon the needs of the client, his family and his social environment.

We do not make medical treatment available for reasons of sympathy. Our civilian program lacks the emotional and patriotic appeal engendered by the gratitude and obligation of a nation to its disabled veterans of the armed forces. Our work has specific objectives, and specific limitations. We cannot become involved in medical care, except insofar as it is related to an employment handicap and a job objective.

It is our special job, whenever practicable, to get the disabled out of bed and out of wheel chairs, and fitted to earn a living. Less we cannot do; more, we may not and should not do as a rehabilitation agency. We do not forget the humanities; our wish to remember them finds ample fulfillment in opening our clients' eyes and minds to a new world full of new opportunities.

We bend every effort toward helping the client forget the leg, the strong back, or the eyes that he can no longer use. Instead, we try, where we cannot cure a handicap, to stimulate toward produc-

continued on next page

tive employment usefulness, the keen mental eyes of the blind, and the untapped physical and mental resources of the crippled. There are some resources which no misfortune can completely tear out of a life. We try to help find and use them.

I should like to invite your attention to the phases of the various services attempted under our program.

I. *REHABILITATION SERVICES PROVIDED*

A. *Physical Restoration:* This includes whatever is done on the medical side, and is placed first, since one of the first steps is a general medical appraisal and diagnostic examination.

B. *Testing:* Intelligence and aptitude tests to determine mental ability and capacity to absorb training. These tests eliminate most of the on-the-job breakdowns.

C. *Guidance and Counseling:* The skilful counselor is worth his weight in gold. He must know something about the 32,000 different jobs at which men work. He must know, or find out enough to keep the arrested TB patient, for example, out of silica dust.

Through his hands pass the application, the medical reports, the initial authorization for treatment, training, tools, equipment, and so forth.

His work caps the climax of physical cure, and with the addition of medical and psychiatric social work, even adds the finishing touches to the picture of complete physical, mental and emotional adjustment to the new life. He needs your constant guidance as physicians and medical social workers. In many of your own cases, he can provide the missing non-medical means of restoring your handicapped patient to productive employment. You will find him a valuable extension of your own services.

D. *Training:* Practically any training for which the individual is fitted by his mental capacity and his aptitudes, may be given. Even a limited, but adequate number of tools of his trade can be furnished, if he is truly indigent. An expensive artificial arm and hand are wasted without training in their use, and training of the remaining normal limb. This *training* is one reason why properly rehabilitated handicapped employees have fewer accidents, work more steadily, have less absenteeism, and equal or exceed their "well" fellow-men on the job. These are employer and insurance company statements.

E. *Placement:* A science in itself. Employers have recognized the fact that, except for a comparatively few individuals kept in civilian life during the recent war because they were classed as essential, the recent most productive industrial period in our history was kept up, as one writer puts it, "by women, old men and 4F's!" The counselor helps the client to select one of the 32,000 kinds of jobs, then sees that he is specifically trained for it.

F. *Follow-up:* That explains itself. Occasionally, especially for the severely handicapped, some smoothing-out of employment conditions is needed, in shops that never before employed "handicapped" workers.

Except in the learned professions, there are few persons seeking employment, who are so specially fitted and selectively placed in the particular job for which they have been specially trained, as the average rehabilitation client. This is another reason for his popularity with employers and insurance companies. Many of them go out of their way to publicize their desire for handicapped employees!

II. *PHYSICAL RESTORATION SERVICES:*

A. *Physical Examination and Diagnosis:* We use a form — it must be a fairly satisfactory one, because half of the doctors call it too long and detailed, and half think it should be longer!

It is not just a form; it is a chart which the counselor and the client will refer to in planning each further step in the process. We do ask, therefore, that it be complete to the last detail. Our answer to the criticism that we ask too much information from the doctor, is that we believe in medical guidance. Since our procedures are made to conform to your prescription, we must be sure that the prescription is not only complete, but that we understand exactly what you do and do not want done.

An example: In a recent survey among blind persons, it was found (where there was any medical record at all), that the most recent physical examinations were nine years old, and that when made, that examination disclosed physical defects in only 1% of blind persons. Why? Because interest in the blindness had resulted in inadequate attention to the "whole man", for obviously, blind people are also susceptible to other defects. Some of these defects might render them completely ineligible for any of our services.

continued on page 688



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VOCATIONAL REHABILITATION PROGRAM

continued from page 686

Other defects must be known to us, or the expensive counselling, training and guidance will be wasted, and we will be criticized for missing an early tuberculosis; an advanced, metastatic carcinoma.

The examiner is — we hope — the family doctor. His positive statement determines the existence of a substantial handicap; and determines whether a reasonable amount of treatment would be a measurable aid in making the client competitively employable.

B. *Review by Medical Consultant:* This man is also a local doctor. He explains the meaning of the terms and conclusions reached to the lay members of the staff, and trains the staff to a recognition of the basic health demands and health risks of industry. He stands by the counselor to assist him in seeing that the medical prescription and the job diagnosis and placement go hand in hand.
He discusses with the physician and the counselor the meaning of the term "static" as applied to a medical condition. He answers such questions as: "Is amputation for osteosarcoma a proper rehabilitation undertaking?" "What about pneumothorax service in arrested TB?" "What can be done to make the diabetic more employable? The epileptic? The psychoneurotic? The cerebral spastic?" This work costs money. However, Clark D. Bridges, Director of Conservation Services of the Zurich Insurance Companies, mentioned in his excellent book "Job Placement of the Physically Handicapped", that one survey has resulted in a report that for every dollar spent on rehabilitation, $47 was returned to society.

C. *Hospital and Nursing Care:* Including physical and occupational therapy.

D. *Corrective Surgery:* Some cases receive nonsurgical treatment as well.

E. *Dental Care:* This is restricted to conditions wherein the dental defect is in itself a substantial employment handicap, or where, in competent medical opinion, it is a necessary part of the treatment of an existing major physical handicap.

F. *Prosthetic Appliances:* This has become a highly specialized field. It has been estimated that as many as 50% of those purchasing artificial limbs do not wear them.

The patient who removes his dentures and eats corn-on-the-cob with his gums; the woman who spent $1000 for a pair of artificial legs and fell flat on her face when she tried to wear them, and thereafter returned to her wheel chair; the girl of 16 who went through school without a limb to fit her thigh-amputation stump, only because someone once told her parents that children should not have artificial limbs fitted until they had "gotten their growth" (!); the man who had a technically perfect Pirogoff amputation, only to learn that no artificial limbs had been made to fit such a stump for 25 years — all these are examples of how not to do things.

It is essential to get the surgeon, the limb manufacturer, the client and the counselor together at the earliest possible moment, preferably before the amputation. The prosthesis must fit not only the patient, but his job requirements. Publicity of the wrong kind has convinced many amputees that they can buy an artificial limb that will do everything a flesh-and-blood limb can do. Such pioneers in the field of cineplastic amputations as Dr. Henry Kessler, emphasize most trenchantly and dramatically their limitations, and plead for a realistic, "demands-of-daily-living" kind of limb.

* * * *

It costs from $200 to $500 a year to keep a handicapped man on the welfare rolls. . . . It costs less than $300 to make him self-supporting at an average wage of $1700 a year, via the doctor, the training, the counselor and the placement route.

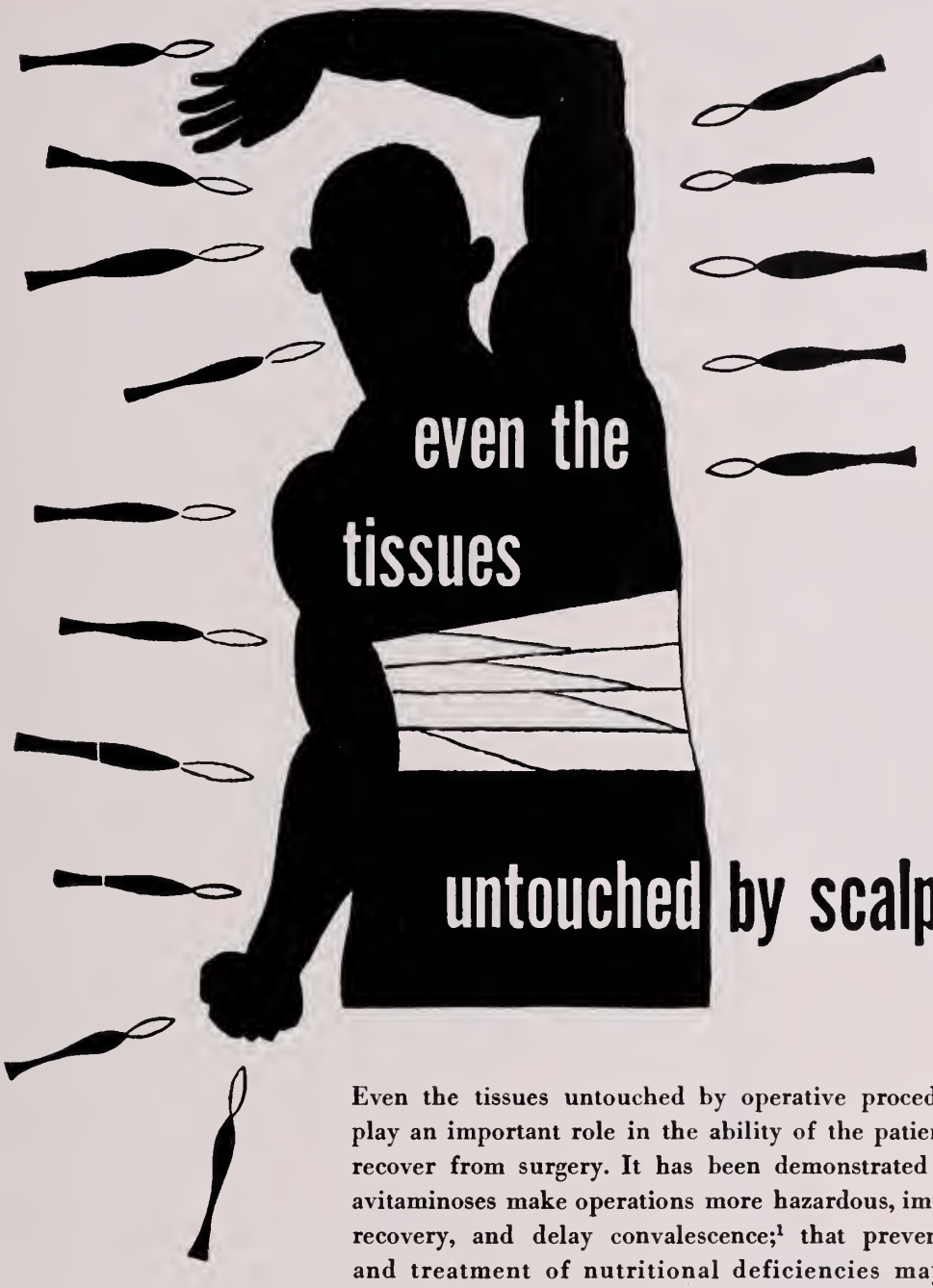
Perhaps 2,000,000 people have severe handicaps. Undoubtedly many more could be added whose handicaps are concealed by reason of pride. A half-million Americans are classed as major amputees, requiring artificial limbs. About 40,000 new major amputees join the ranks of the crippled every year. Even during the recent war, civilian major amputees outnumbered the military cases, 3 to 1.

Rehabilitation in the TB Sanatorium

Of our 600,000 cases of active tuberculosis, many should some day support themselves. In sanatoria which have introduced rehabilitation services, the number of those leaving the "san" without medical permission has been cut 90%! Four out of five who so leave, were formerly reported dead within five years. Rehabilitation, started as soon as medically permissible, encourages the will to get well. The saving of lives is dramatic.

Equally brilliant is the effect upon the future health of those who complete their stay in the

continued on page 691



Even the tissues untouched by operative procedures play an important role in the ability of the patient to recover from surgery. It has been demonstrated that avitaminoses make operations more hazardous, imperil recovery, and delay convalescence;[1] that prevention and treatment of nutritional deficiencies may be "decisive"[2] in recovery following surgery. In the field of oral and parenteral vitamins, Upjohn offers a full range of highly potent, convenient to administer, economical vitamins.

1. Virginia M. Monthly **72**:240 (June) 1945.
2. Am. J. Surg. **54**:299 (April) 1942.

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Details of administration accompany each package of SOLGANAL-B OLEOSUM; or they may be obtained by writing the Medical Research Division.

1. Ragan, C., and Boots, R. H.: New York Med. 2:21, 1946.

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VOCATIONAL REHABILITATION PROGRAM

concluded from page 688

"san" and are dismissed as "arrested". Of those who are dismissed without having had rehabilitation services, six times as many break down and return with reactivated tuberculosis. Counseling, training and selective placement in "safe" employment has proved to pay rich dividends in time, health, public safety and public money. I dislike to paint too glowing a picture of success in dealing with a disease as subtle as tuberculosis, so I suggest only that if you wish to find an amazing and inspiring conclusion, calculate from these figures rehabilitation's saving in lives of the tuberculous in terms of 100 active cases, or of 100 sanatorium admissions!

In paying the costs of medical services, we must remember that since these clients are required to demonstrate inability to pay for their care, the ordinary test of a fee based upon a reasonable ability to pay does not apply. There are no "charity" cases, for which you receive nothing. There are no well-to-do patients to carry your overhead and to compensate you in part for your "free" cases.

The fees agreed upon between the State Rehabilitation Agencies and the State Medical Societies are, in my own experience, always at about the level of average charges to patients of moderate means. They are not "welfare" rates, and are set up in accordance with the principle that a good medical diagnosis and thorough medical treatment are well worth their cost.

In closing, I want to urge the medical and economic soundness of getting more cases *from* doctors as clients, as well as getting more cases *to* doctors as patients. The closer the timing between medical services and rehabilitation, the cheaper, the better and the more satisfying is the end result. We doctors and medical social workers can now get our patients back on their feet without the years of discouragement that come to the jobless object of charity.

Most of the medical guidance of this program comes from the practicing doctors in the patient's own community and State. Medicine is just coming into its own in rehabilitation. The program has some "bugs", as does any new undertaking. The closer we can bring the family physician to the rehabilitation counselor, the fewer will be the complaints, the difficulties and the failures.

My message to the Rhode Island Medical Social Workers and to the State Medical Society itself, is a plea for more medical guidance from those best qualified to give it — those to whose care the welfare of the lame, the halt and the blind has been committed since the beginnings of civilization — the practitioners of the healing art.

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DISTRIBUTION OF STREPTOMYCIN

Limited commercial distribution of streptomycin through designated hospitals for treatment of civilian patients will begin September 1, the Civilian Production Administration announced recently.

The plan, which is similar to that used initially for penicillin distribution, was authorized by amending Schedule 119 to Order M-300.

CPA officials said that more than 1,600 general hospitals have been selected as depots for the drug and will supply other hospitals in their respective areas. They were selected with the assistance of an advisory panel including Dr. Chester S. Keefer, National Research Council; Dr. C. J. Van Slyke, U. S. Public Health Service; and Dr. Victor Johnson, American Medical Association. Pending their notification, the names of the depot hospitals were not released by the Chemicals Division.

Until now the small amount of streptomycin available has been distributed by CPA to meet the urgent needs of the Army, Navy, Public Health Service, Veterans Administration, and also to the National Research Council to carry on as integrated clinical research program to determine the conditions amenable to streptomycin treatment. Streptomycin producers have contributed nearly $1,000,000 to finance the program carried on by the Council's Committee on Chemotherapeutic and Other Agents under the chairmanship of Dr. Chester S. Keefer.

Until September 1, civilian appeals for this drug will continue to be met only from the supply available under the clinical research program. Appeals should be made by the physician in charge of the case to Dr. Keefer, Evans Memorial Hospital, 65 East Newton Street, Boston, Mass.

Beginning September 1, physicians should contact their local hospitals to obtain the drug. CPA's Chemicals Division shortly will give civilian hospitals full information about the distribution plan, the names of depot hospitals and copies of Dr. Keefer's report on the indications, contraindications, mode of administration, dosage and toxic effects of streptomycin. Depot hospitals will be notified of their September allotments of the drug and told who their suppliers will be.

Chemicals Division officials emphasized that the distribution plan provides that depot hospitals place their orders direct with the designated suppliers, an important difference from the plan used in the initial distribution of penicillin by the War Production Board.

So that the sharply limited supply of streptomycin will be of most use to the greatest number of patients, CPA recommends Dr. Keefer's report as a guide for use of the drug.

The Keefer report summarizes 1,500 cases reported by physicians from all parts of the United States. It particularly recommends use of the drug for treatment of tularemia, hemophilus influenzae infections, bacteremia due to gram negative organisms, urinary tract infections, and meningitis due to certain specific organisms. Streptomycin has been found to be of questionable value in typhoid fever, brucellosis and salmonella infections and to be ineffective in clostridia infections, malaria, rickettsial infections, virus infections and infections with mold and fungi.

The report includes tuberculosis among a number of diseases for which the drug is a helpful agent but states that in the treatment of these its status has not been definitely defined. It emphasizes that streptomycin will not replace any of the established forms of treatment and that it should not be used as a substitute for other forms of therapy.

Because of the large quantity of streptomycin (a minimum of 135 to 270 grams) needed to treat tuberculosis, the present supply will not be sufficient for general use against

continued on page 697



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THE WASHINGTON SCENE

ALTHOUGH Congress recessed last month without taking final action on several proposed measures involving controversial issues in the field of health and medical legislation, it should be carefully noted that these measures are not dead, but are merely dormant. There is a persistent rumor in the nation's capital, confirmed by a statement from the Senate floor on August 2, that the President will call an extra session of Congress for the express purpose of trying to push through social legislation that has been by-passed. The answer lies in part in the fact that if the House should go Republican in the November elections the President would face a trying two year period prior to the presidential campaign, and it might be impossible for him to get favorable action on some of the remaining portions of his legislative program. Anything can happen from now until the end of the year with clever legislative strategy being employed with respect to the Wagner act and the Pepper bill.

Some of the significant actions taken as the 79th Congress wound up its affair prior to the recess may be summarized as follows:

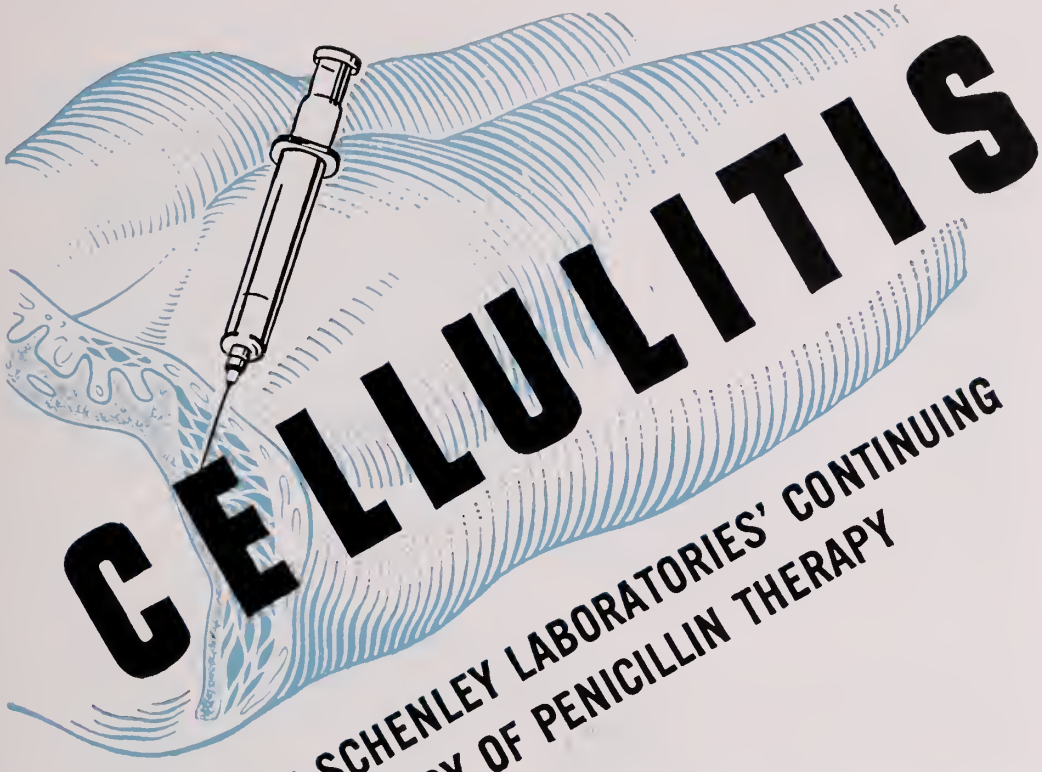
HILL-BURTON BILL. This measure to provide for the expansion of hospital facilities in the States had the approval of the American Medical Association, and the various hospital groups. The Senate Education and Labor Committee worked on the bill for two months in executive sessions and gave much thought to the formula for the distribution of funds. It devised one that would aid the poor States to obtain health centers and hospitals sorely needed. However, the House changed the formula when it received the bill, reducing the Federal matching grant to 33⅓ per cent, thus militating against some of the very sections of the country that probably should be aided most. Referred back to the Senate the formula was set at 40 per cent by a compromise amendment. The law thus will still give the wealthy jurisdictions a chance to obtain federal grants while impoverished communities will be unable to participate in many instances.

MATERNAL AND CHILD WELFARE. The much-discussed and much-debated Pepper bill which drew strong opposition was not approved by the Committee on Education and Labor, and as a compromise a joint resolution was introduced amending title V of the Social Security Act to provide for increased grants to States for maternal and child-health services, services for crippled children, and child welfare services. This resolution went to the Senate finance committee which slashed the proposed raise in funds to $30 million to $23 million. Even at that the increase about doubled the Children's Bureau grants and for the moment that Bureau has more money but no more power. It is safe to predict that there will be a renewal of the campaign for the original Pepper bill provisions, especially now that the Children's Bureau has been transferred to the already powerful Social Security Board with an additional $425,000 for administration.

MENTAL HEALTH AND MENTAL HYGIENE. The mental health bill which had the support of medical groups was enacted, but despite strong support for a mental hygiene program to be developed by the Public Health Service, and despite the fact that the Senate approved funds therefor on August 1, House and Senate conferees omitted the entire appropriation from the 1947 appropriation bill the following day. It is reported that conferees thought the USPHS already had adequate funds under existing law to make a start on the program.

CANCER RESEARCH. Several reasons have been advanced for the defeat of the measures proposing programs and appropriations for cancer research. Probably the most reasonable ones are that the bills were too loosely drawn, the requests for federal support were not substantiated by prepared exhibits demonstrating need, and the fact that public and private groups failed to agree on the planning. The emotional appeal of this type of legislation was very evidently outweighed by the lack of clear statement showing why up to $100 million are needed, where research laboratories would be built, and at what cost, etc.

NATIONAL HEALTH INSURANCE. Hearings on the Wagner Act were discontinued in July, but the printed reports of the hearings, top heavy with those of proponents for compulsory federal control, will undoubtedly be used to good advantage by those seeking to win public support for this type of legislation during the coming months. The national high school debate question for the coming academic year will be on the question of national health insurance, and it is safe to predict that the Wagner hearings will be widely quoted.



CELLULITIS

No. 3 IN SCHENLEY LABORATORIES' CONTINUING SUMMARY OF PENICILLIN THERAPY

Cellulitis caused by penicillin-sensitive organisms readily responds to penicillin therapy. By the early administration of penicillin in adequate doses, suppuration may be prevented and prompt resolution of the inflammatory process obtained. When abscess formation has occurred, penicillin will localize and control the infection but surgical evacuation of the purulent material may be required to effect a cure.

The administration of penicillin combined, when indicated, with surgical, supportive, and other measures, will in most instances rapidly control and eradicate the infection. Thus, the duration of the disease is shortened, and the possibility of complications reduced to a minimum.

A daily total of 160,000 to 480,000 units, depending upon the severity of the infection, in divided doses every 2 to 3 hours by the intramuscular route will usually be adequate to effect a cure. Duration of the course will depend upon response to therapy. If thought desirable, as a supplement to parenteral administration, penicillin may be employed by local injection or instillation of solutions containing 5,000 to 50,000 units per cc.

WOLLGAST, C. F.: *The Clinical Use of Penicillin: A Report of 115 Cases Treated in an Army Hospital, Texas State J. M. 40:225 (Aug.) 1944.* FARQUHARSON R. F.; GREEY, P., & TOWNSEND, S. R.: *Results of Penicillin Therapy: A Report for the Joint Services Penicillin Committee, Canad. M. A. J. 53:1 (July) 1945.*

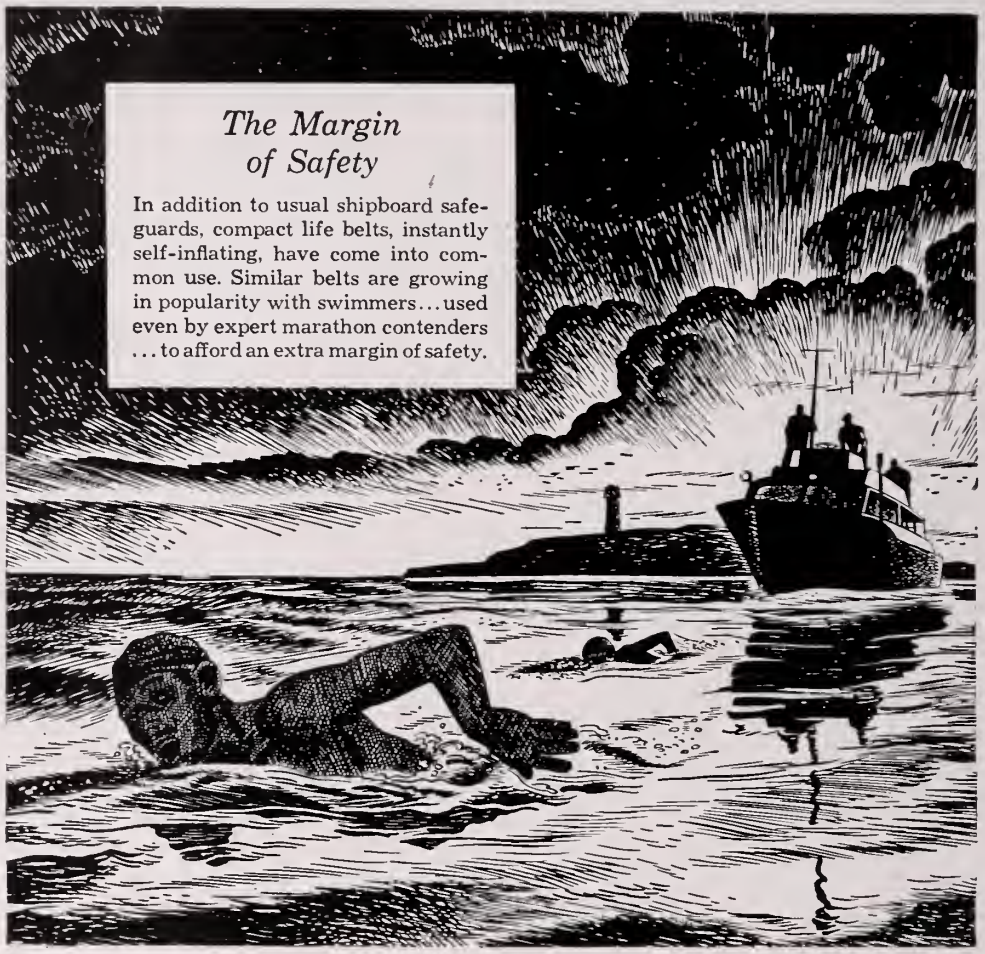
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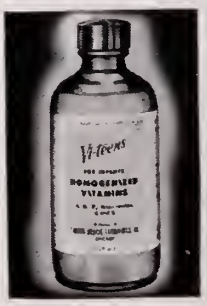
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Vitamin C	40 Milligrams
Vitamin D	800 U.S.P. Units
Niacinamide	4 Milligrams



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DIETHYSTILBESTROL IN THE PREVENTION OF ORCHITIS FOLLOWING MUMPS

concluded from page 662

TABLE III

"Hospital Orchitis"

Untreated	*Treated with Diethylstilbestrol*
16.9%	3.9%

Conclusions

Seventy-seven patients with mumps were treated with diethylstilbestrol. Three of them developed orchitis after treatment was started. One hundred sixty-eight patients did not receive diethylstilbestrol. Twenty-eight of these patients developed orchitis. This form of therapy reduced the incidence of hospital orchitis from 16.6 per cent to 3.9 per cent. Diethylstilbestrol was not found to be toxic in the dose employed.

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DISTRIBUTION OF STREPTOMYCIN

concluded from page 692

this disease. The average allotment to a depot hospital for all purposes would treat only one tuberculosis patient. In recognition of this fact the committee warns that no patient with tuberculosis should be started on streptomycin without assurance that an adequate quantity will be obtainable.

CPA said that the great quantity of the drug required for tuberculosis study had made it impossible to supply the amount needed adequately to evaluate the role of streptomycin in treatment of the disease.

However, CPA proposes to make available from the increased supply a considerable quantity for continuing clinical research on tuberculosis. Plans for coordinated research under a suitable sponsoring organization are now being considered.

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(As of September 1, 1946)

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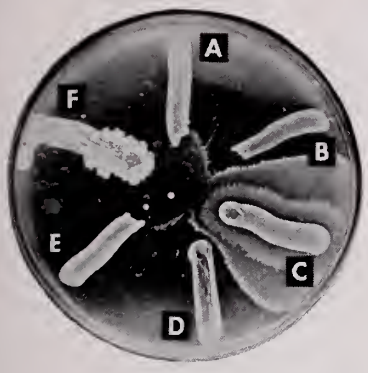
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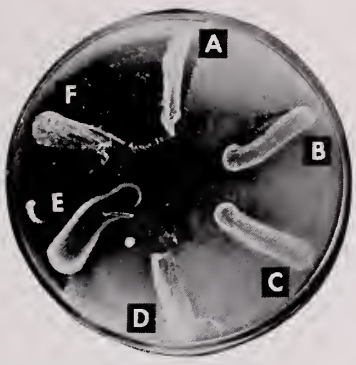
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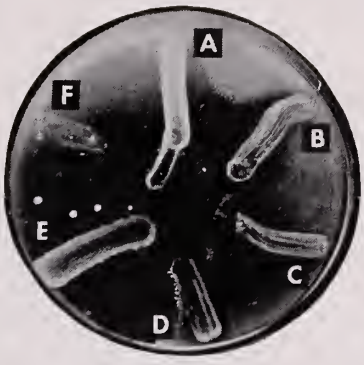
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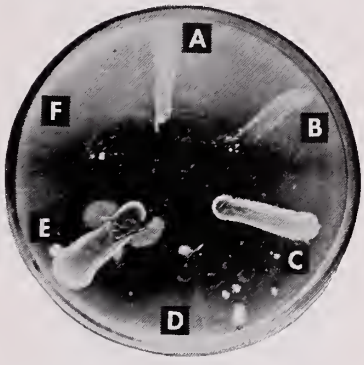
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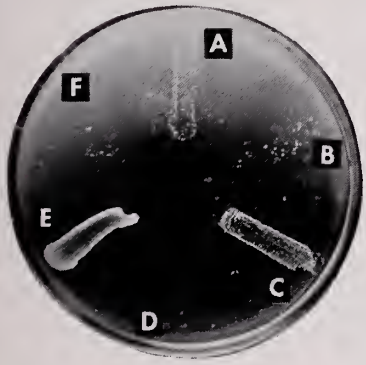
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Antibacterial Activity of STREPTOMYCIN

KEY TO PHOTOGRAPHS: • A. *Escherichia coli*
B. *Eberthella typhosa* • C. *B. proteus* • D. *Klebsiella pneumoniae*
E. *Bacillus pyocyaneus* • F. *Mycobacterium tuberculosis*
The numerals indicate micrograms of Streptomycin per cc. of agar.



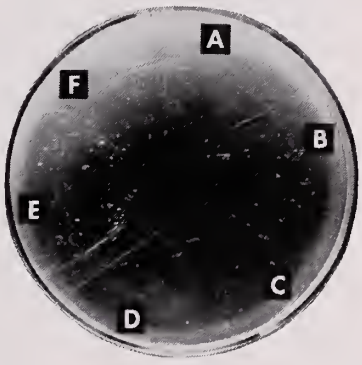
1.6



6.4



26.



104.

THESE photographs show the inhibitory action of increasing concentrations of Streptomycin on a strain of six representative organisms *in vitro*. Inhibitory levels of concentration vary significantly with different strains.

Streptomycin exhibits a wide range of antibacterial activity *in vitro* and *in vivo* against both gram-positive and gram-negative organisms. Clinical results do not necessarily parallel *in vitro* activity or therapeutic results in experimental animals.

In clinical practice, Streptomycin is especially interesting because of its effectiveness against susceptible gram-negative organisms. The most noteworthy results to date have been obtained in the infections listed at the right.

Our production of Streptomycin is being rapidly expanded. However, due to the present shortage, Streptomycin was placed on allocation by the Civilian Production Administration effective March 1, 1946. At present, civilian distribution may be authorized only by Dr. Chester Keefer, Evans Memorial Hospital, Boston, Mass., Chairman of the Committee on Chemotherapeutic and Other Agents of the National Research Council.

URINARY TRACT INFECTIONS
due to
susceptible gram-negative organisms

TULAREMIA

MENINGITIS
due to *Hemophilus influenzae*

WOUND INFECTIONS
due to
susceptible gram-negative organisms

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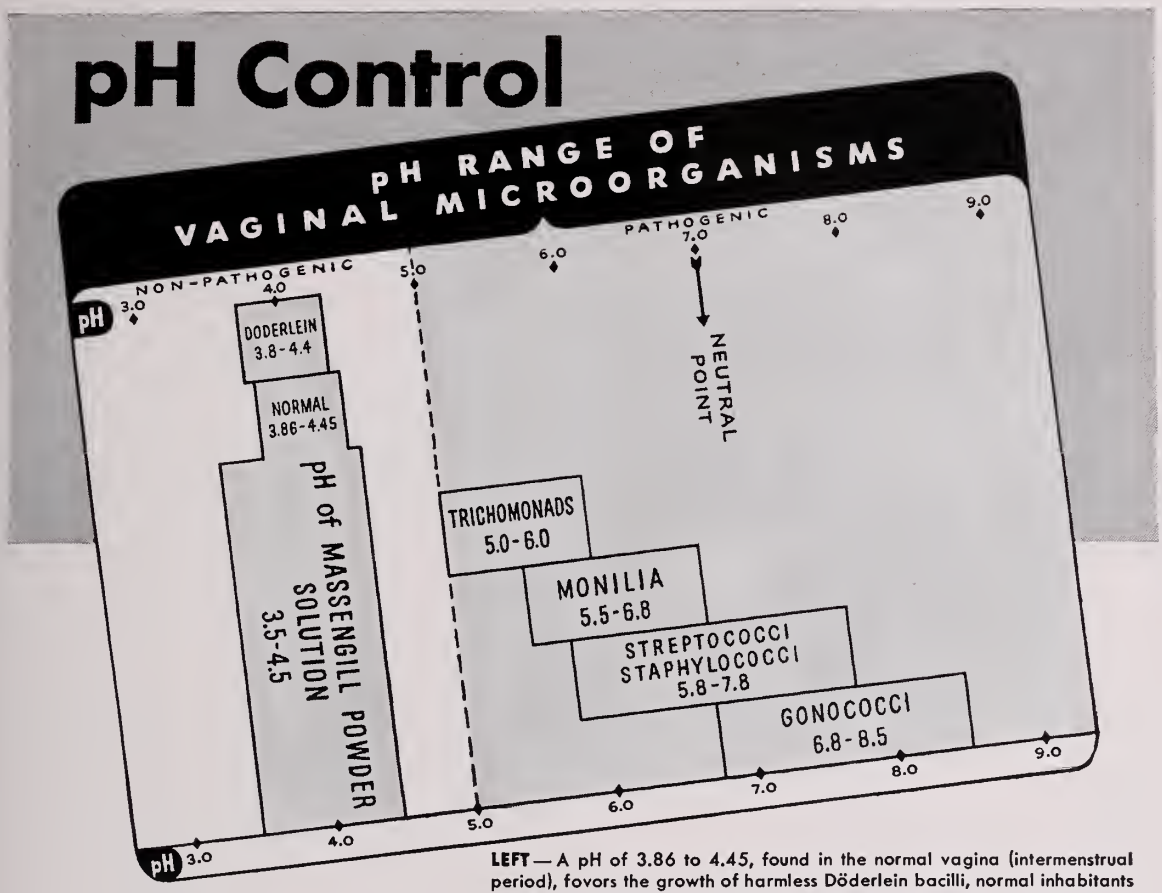
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pH Control



LEFT— A pH of 3.86 to 4.45, found in the normal vagina (intermenstrual period), favors the growth of harmless Döderlein bacilli, normal inhabitants of the vaginal tract. Massengill Powder solution presents a pH of 3.5 to 4.5.

RIGHT—The pH range, 5.0 to 9.0, most favoroble to the development of pathogenic orgonisms.

SINCE the average woman wants and needs advice regarding a proper douche, her physician is confronted by the problem of choosing an effective preparation which is safe, noncaustic and nonirritating. Massengill Powder may be recommended with assurance because it combines therapeutic efficacy, preventive action and hygienic value, with virtual freedom from irritant properties. Its particular advantage lies in control of vaginal pH.

The normal vagina is protected against the influence of pathogenic organisms by a pH incompatible with their growth. Hence restoration of a normal pH presents the simplest, most direct form of vaginal therapy. Massengill Powder, by providing the desired pH, represents a powerful antibacterial weapon.

Due to its effect upon vaginal pH and to its cleansing action, Massengill Powder solution is equally suitable for regular use in personal hygiene and in the therapy of a wide range of vaginal affections.



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Massengill Powder is supplied in glass jars in 3-oz., 6-oz., 16-oz., and 5-lb. sizes.

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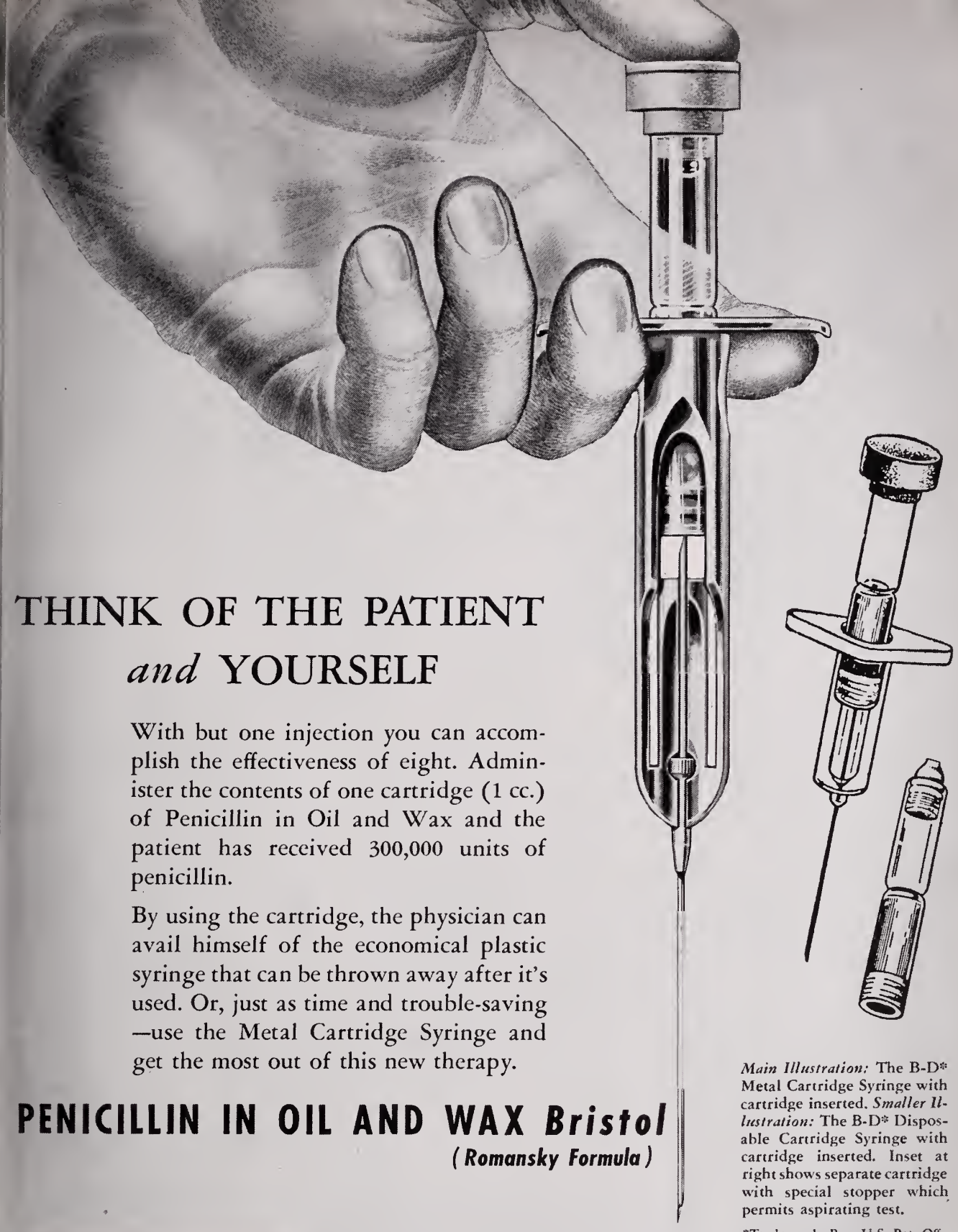
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Main Illustration: The B-D* Metal Cartridge Syringe with cartridge inserted. *Smaller Illustration:* The B-D* Disposable Cartridge Syringe with cartridge inserted. Inset at right shows separate cartridge with special stopper which permits aspirating test.

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Newport County Medical Society	James C. Callahan Samuel Adelson	Norman M. MacLeod	President, A. M. Tartaglino Vice Pres., Wm. A. Stoops 2nd Vice Pres., P. P. Ciarla Secretary, H. W. Brownell Treasurer, N. U. Zielinski Censors: N. M. MacLeod John A. Young	4th Tuesday of every other month—Jan., Mar., May, July, Sept., Nov.—usually no July meeting held	January
Pawtucket Medical Association	Earl J. Mara Robert Henry Charles L. Farrell Henry Hanley	James L. Wheaton Earl F. Kelly (alternate)	President, Wm. N. Kalcounos Vice Pres., Earl J. Mara Treasurer, L. A. Senseman Secretary, K. W. Hennessey	On or after 3rd Thurs. of each month at time and place designated by the Pres. (except July-August)	March
Washington County Medical Society	Linwood H. Johnson Julianna R. Tatum	John P. Jones	President, S. P. Turco Vice Pres., Louis Morrone 2nd Vice Pres., S. A. Capalbo Sec'y-Treas., J. R. Tatum	January, April, July, October — on second Wednesday of the month	January
Woonsocket Medical Society	H. Lorenzo Emidy Francis King	James McCarthy Saul Wittes (alternate)	President, Joseph Reilly Vice Pres., Richard Dowling Secretary, Alfred King Treasurer, Paul Boucher Censors: E. L. Tremblay George Crepeau Joseph McKenna	2nd Tuesday, alternate months, Sept.-June	Elective
Providence Medical Association	Bertram H. Buxton H. G. Calder A. V. Migliaccio A. Henry Fox Arcadie Giura Alex. M. Burgess Emery M. Porter Henry E. Utter George W. Davis Kalei K. Gregory Edward V. Famiglietti Peter F. Harrington	Emery M. Porter	President, Paul C. Cook Vice Pres., Guy W. Wells Secretary, Frank Cutts Treasurer, Wm. P. Davis	1st Monday of each month; Oct. — May inclusive	January

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Society	*Officers*	*Annual Meeting*	*Chairman, Elected Committees*
Rhode Island Medical Society	President, Herman C. Pitts Vice President, Michael H. Scanlon President Elect, Arthur H. Ruggles Secretary, Morgan Cutts Treasurer, Charles J. Ashworth Ass't Secretary, Charles B. Ceppi Ass't Treasurer, G. Raymond Fox	May 15 and 16, 1946 at Rhode Island Medical Society Library, 106 Francis Street Providence 3, R. I.	Philip Batchelder and Merle M. Potter, Auditors Stanley Sprague, Committee on Industrial Health Russell S. Bray, Committee on the Library Alex M. Burgess, Committee on Postgraduate Education Arthur H. Ruggles, Committee on Medical Economics William H. Foley, Committee on Public Laws Guy W. Wells, Committtee on Public Policy and Relations John E. Donley, Committee on Publication Herman C. Pitts, Committee on Scientific Work and Annual Meeting



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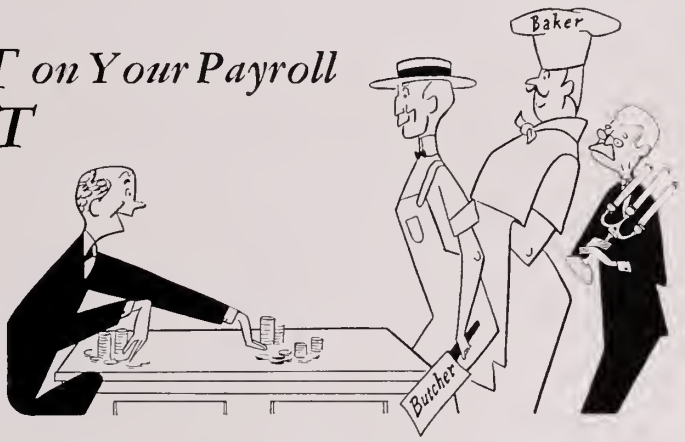
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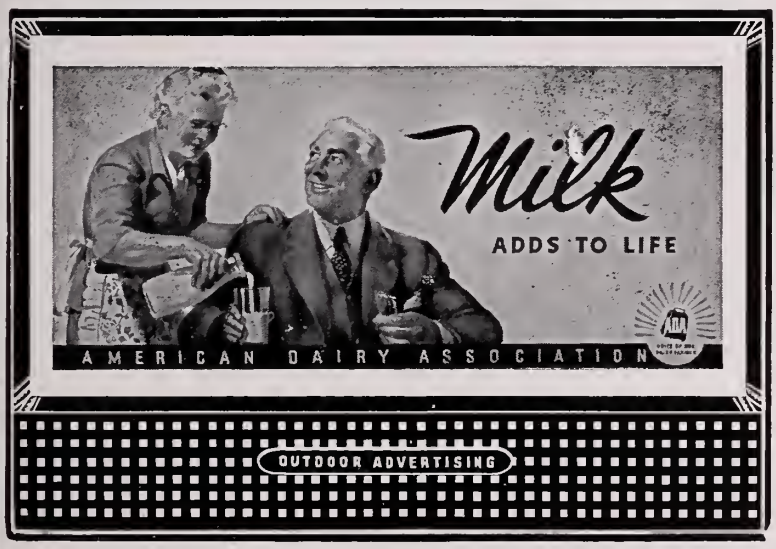
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---

[1] Tillett, W. S., Cambier, M. J., and McCormack, J. E.: The Treatment of Lobar Pneumonia and Pneumococcal Empyema with Penicillin, Bull. New York Acad. Med. *20*:142, March, 1944.

[2] Armstrong, S. H., Jr.; England, A. C., Jr.; Favour, C. B., and Scheinberg, I. H.: Anemia and Hypoproteinemia Complicating Severe Protracted Pneumonia: Treatment with Penicillin—Role of Specific Supportive Therapy in Recovery, J.A.M.A. *127*:303 (Feb. 10) 1945.

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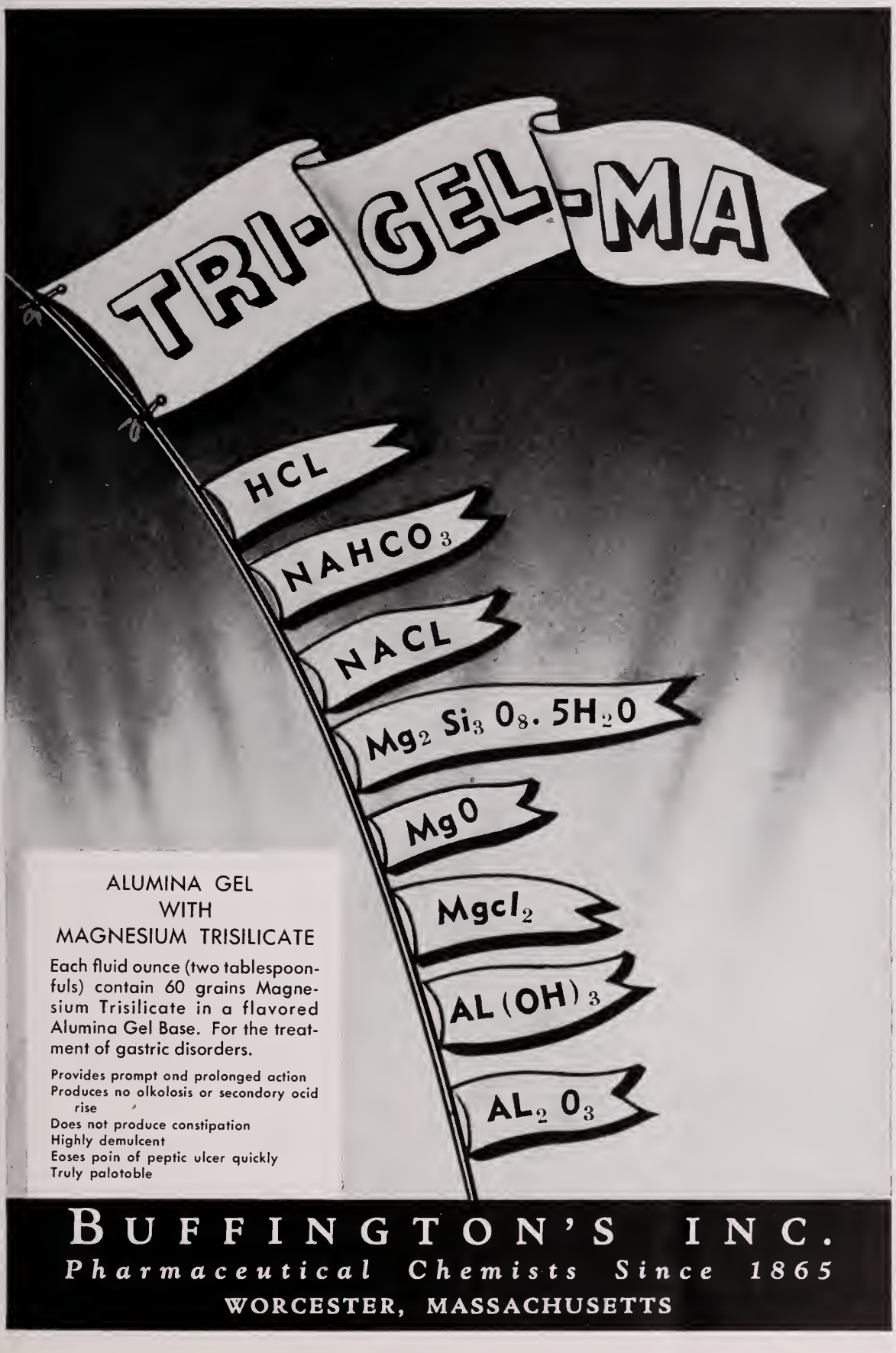
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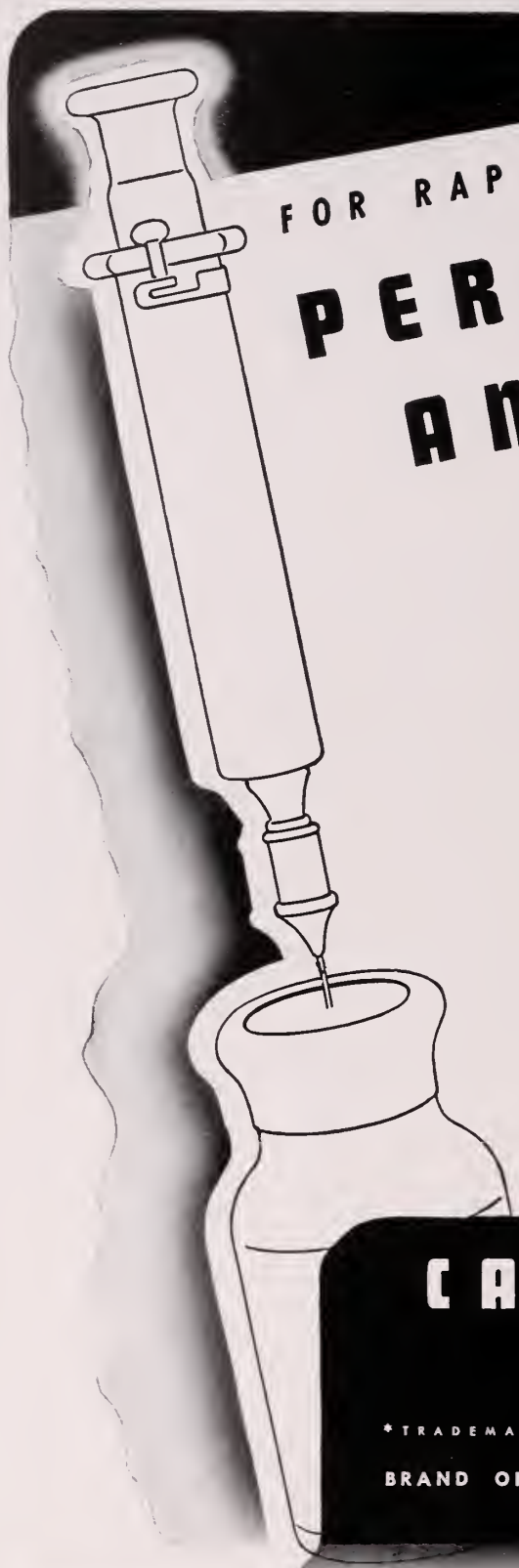
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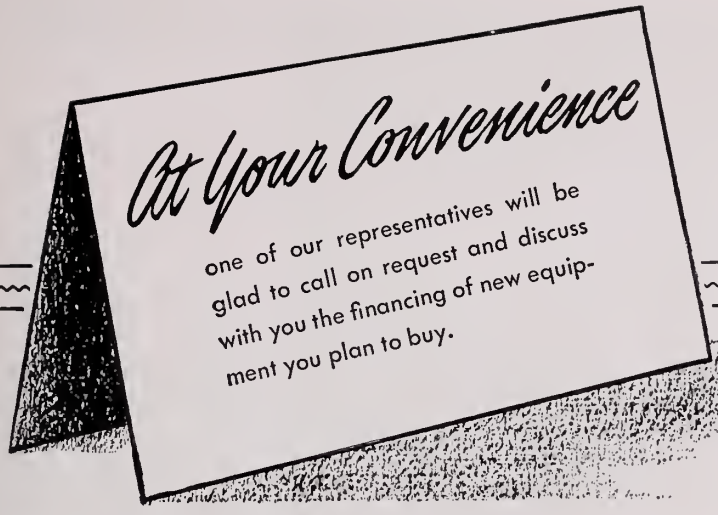
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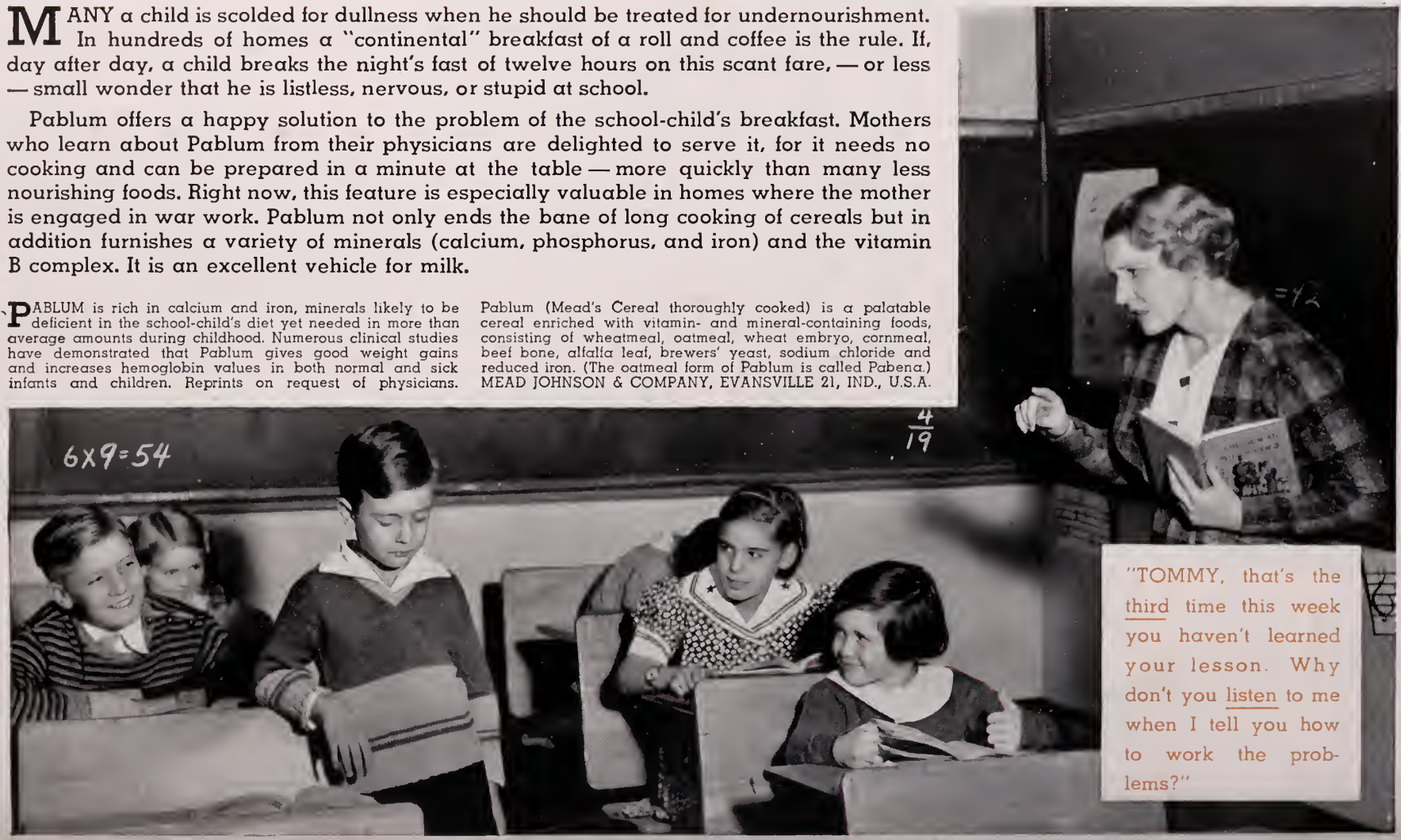
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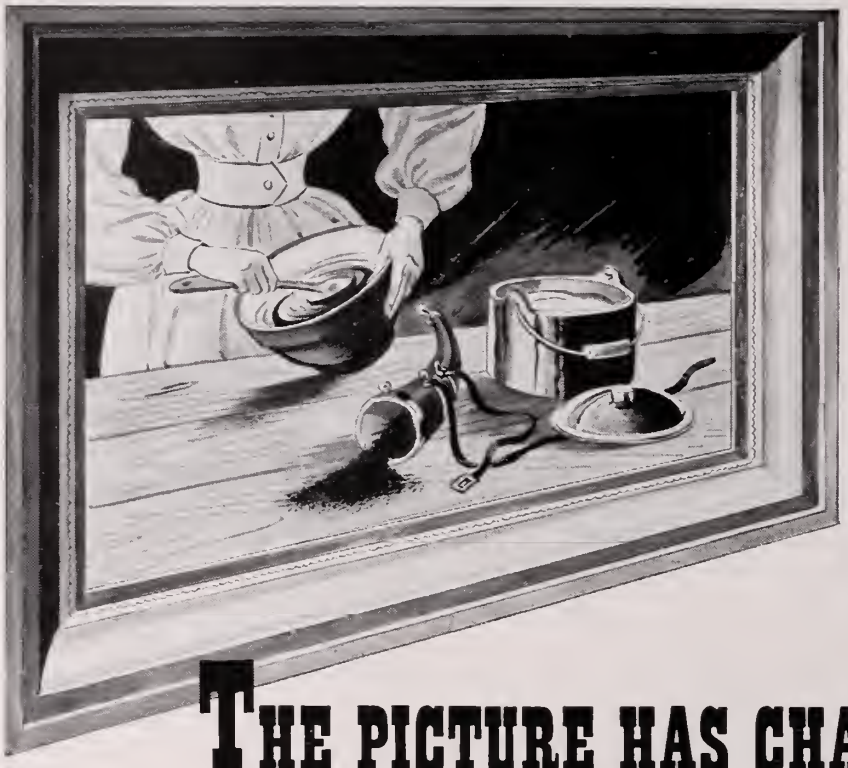
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THE RHODE ISLAND MEDICAL SOCIETY • HOSPITAL ASSOCIATION OF RHODE ISLAND

Volume XXIX, No. 10

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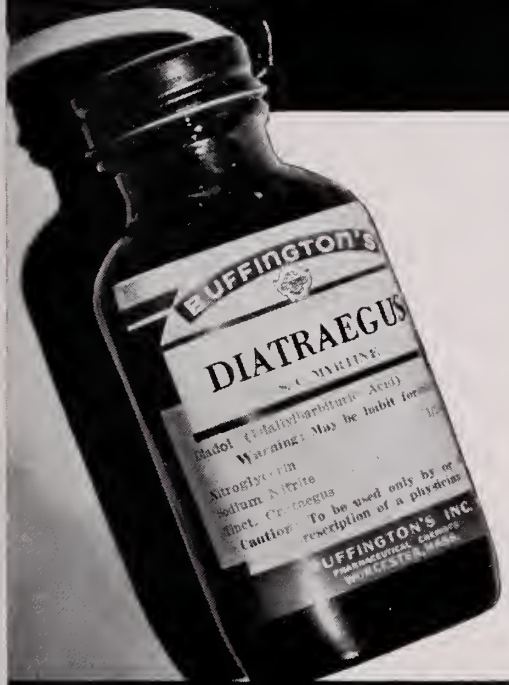
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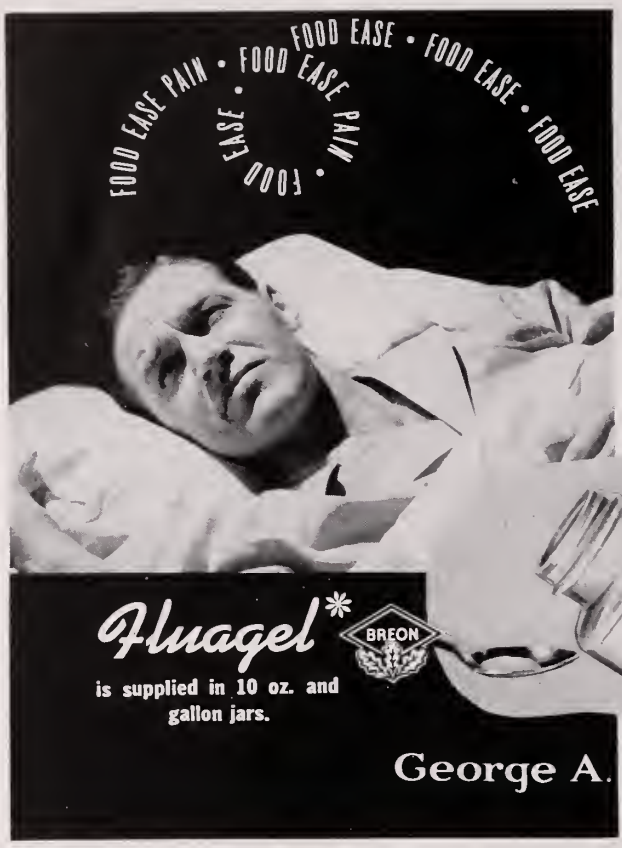
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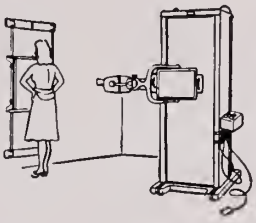
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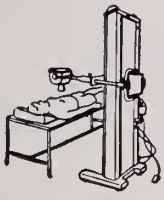
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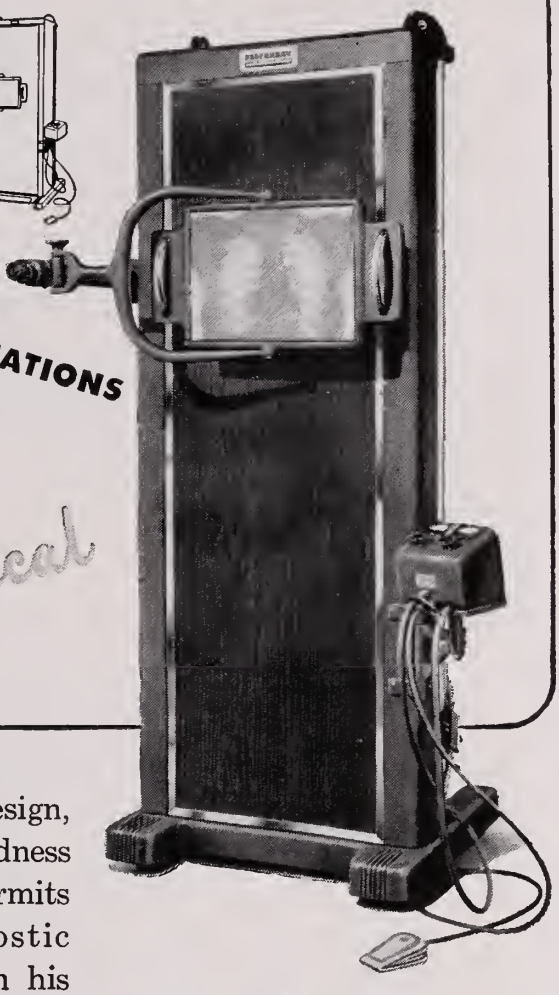


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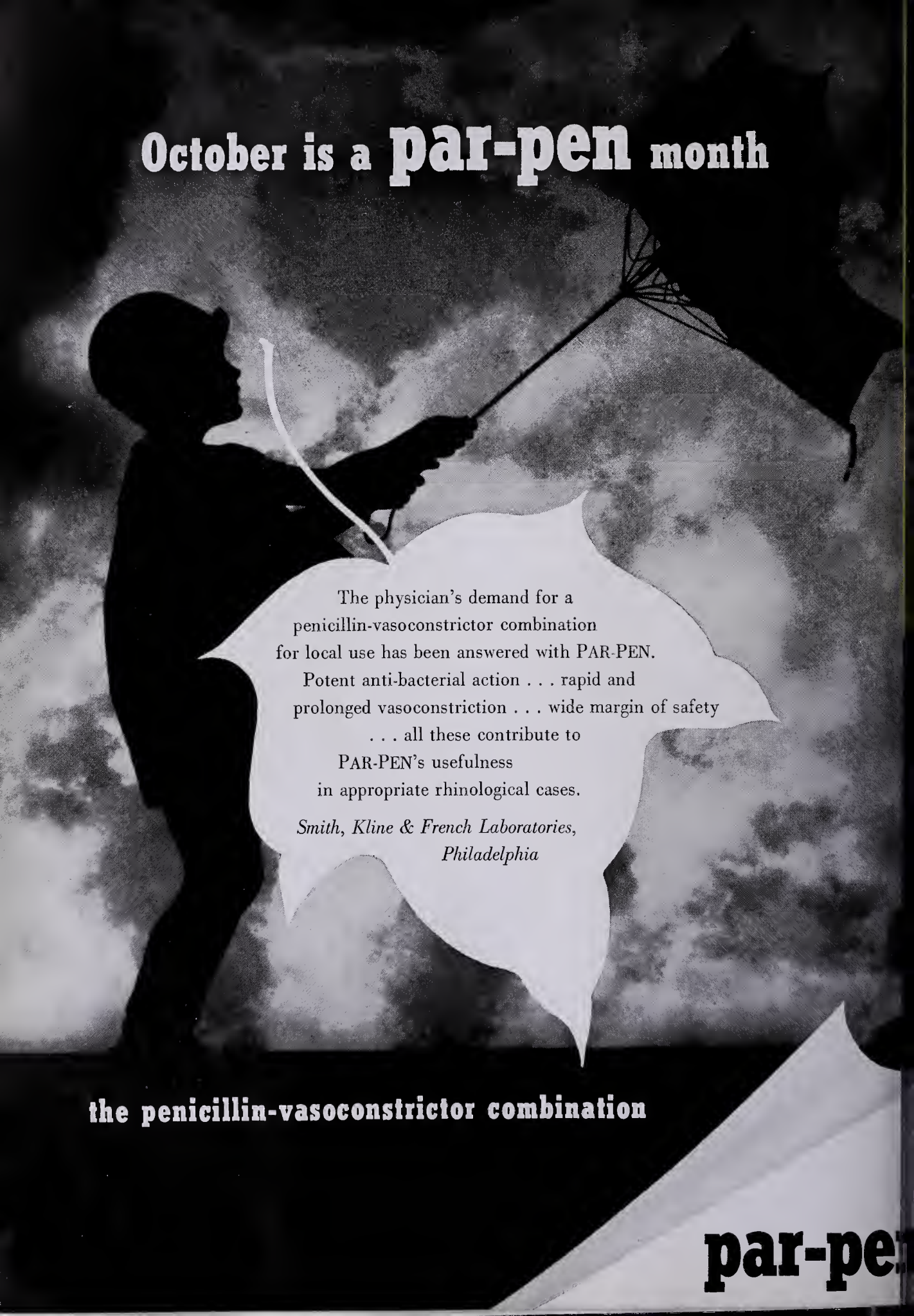
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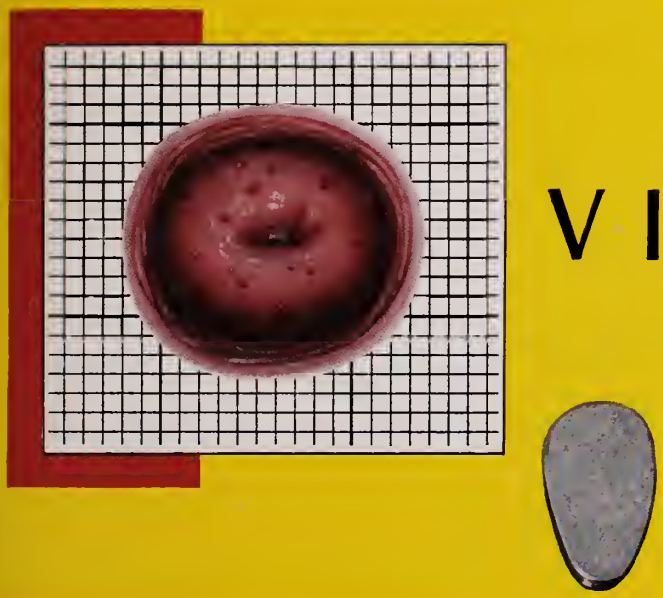
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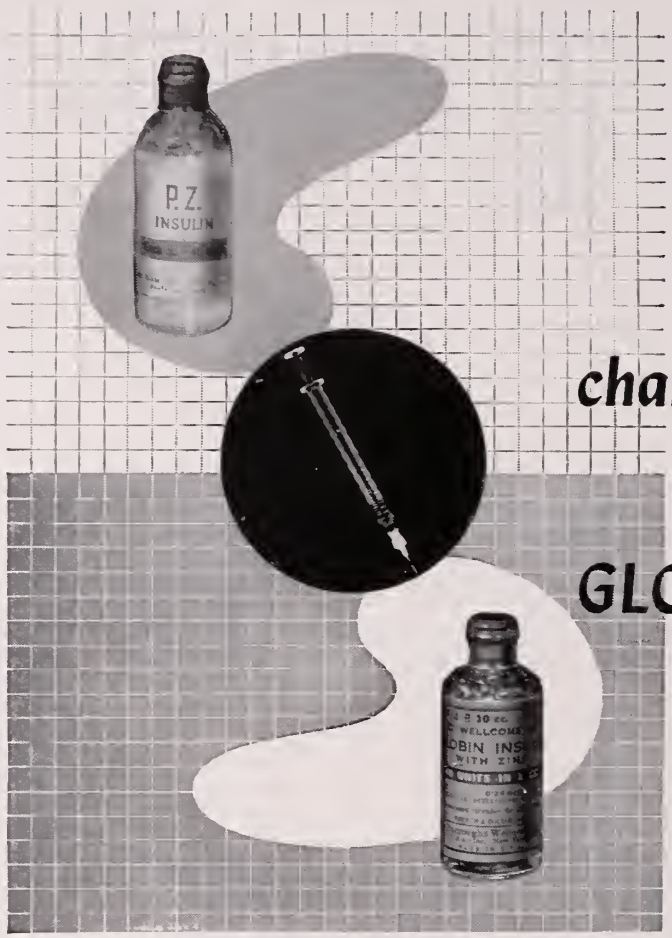
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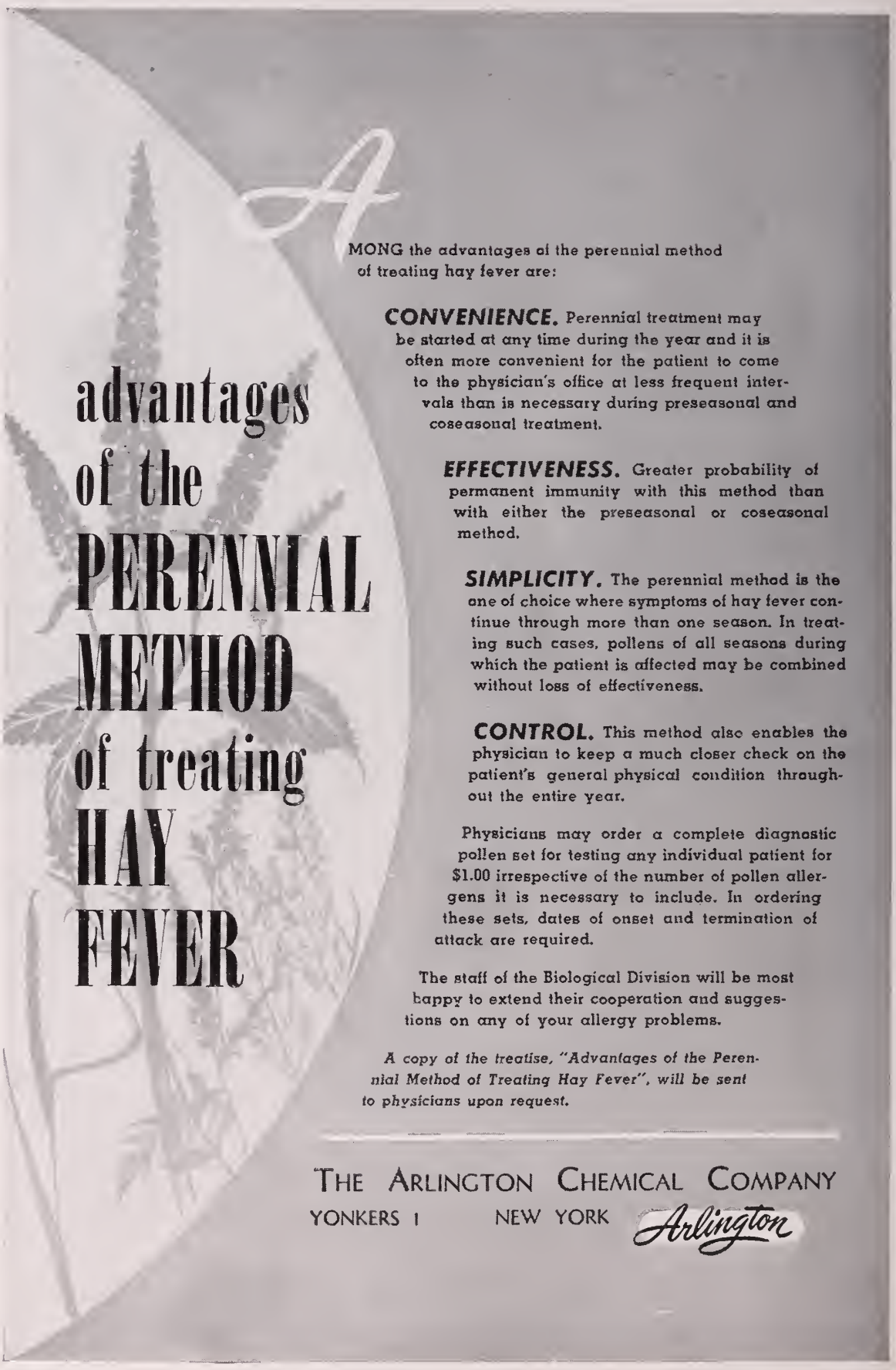
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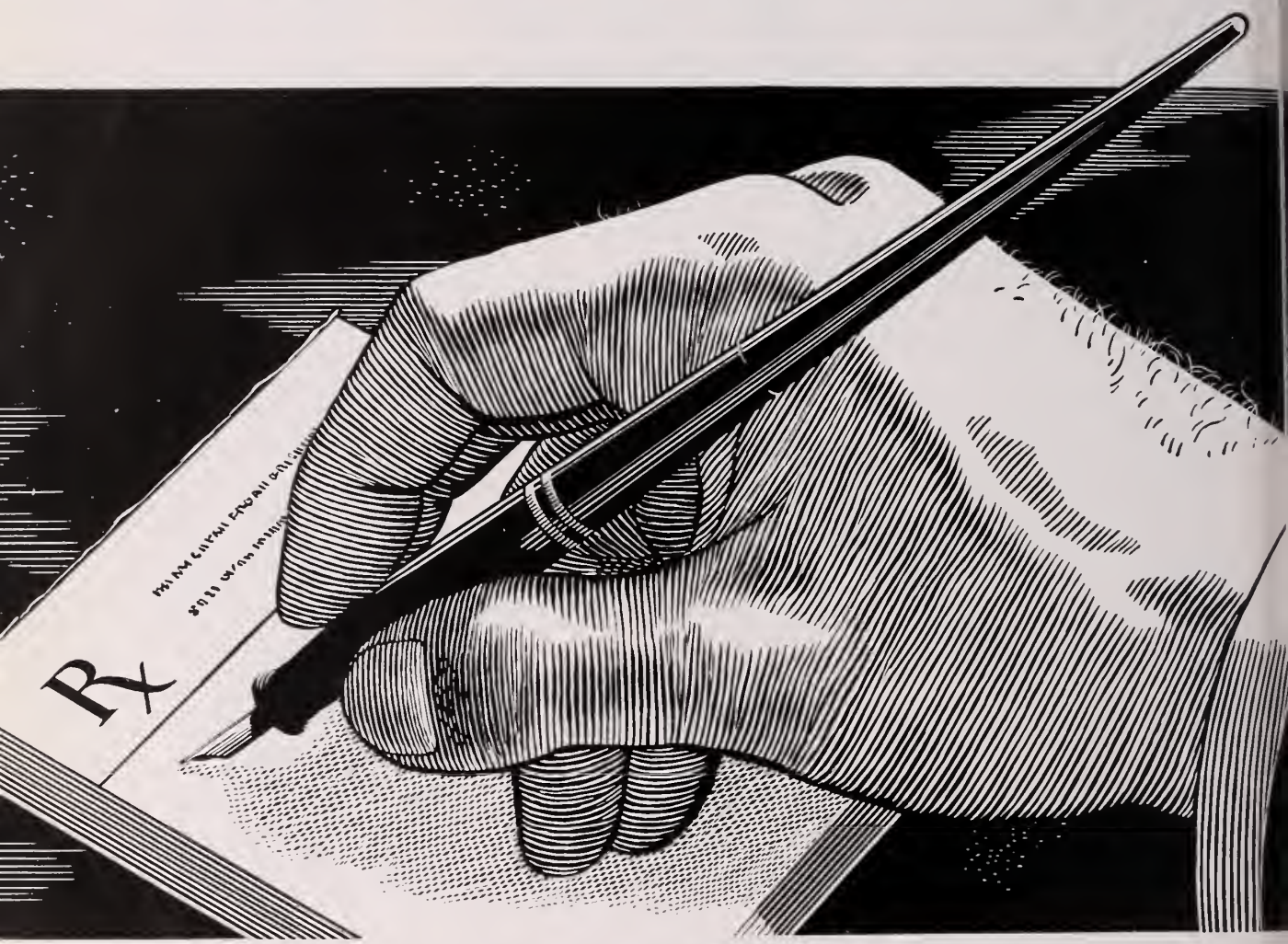
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*Jolliffe, N.: J.A.M.A. **129**:613 (Oct. 27) 1945.

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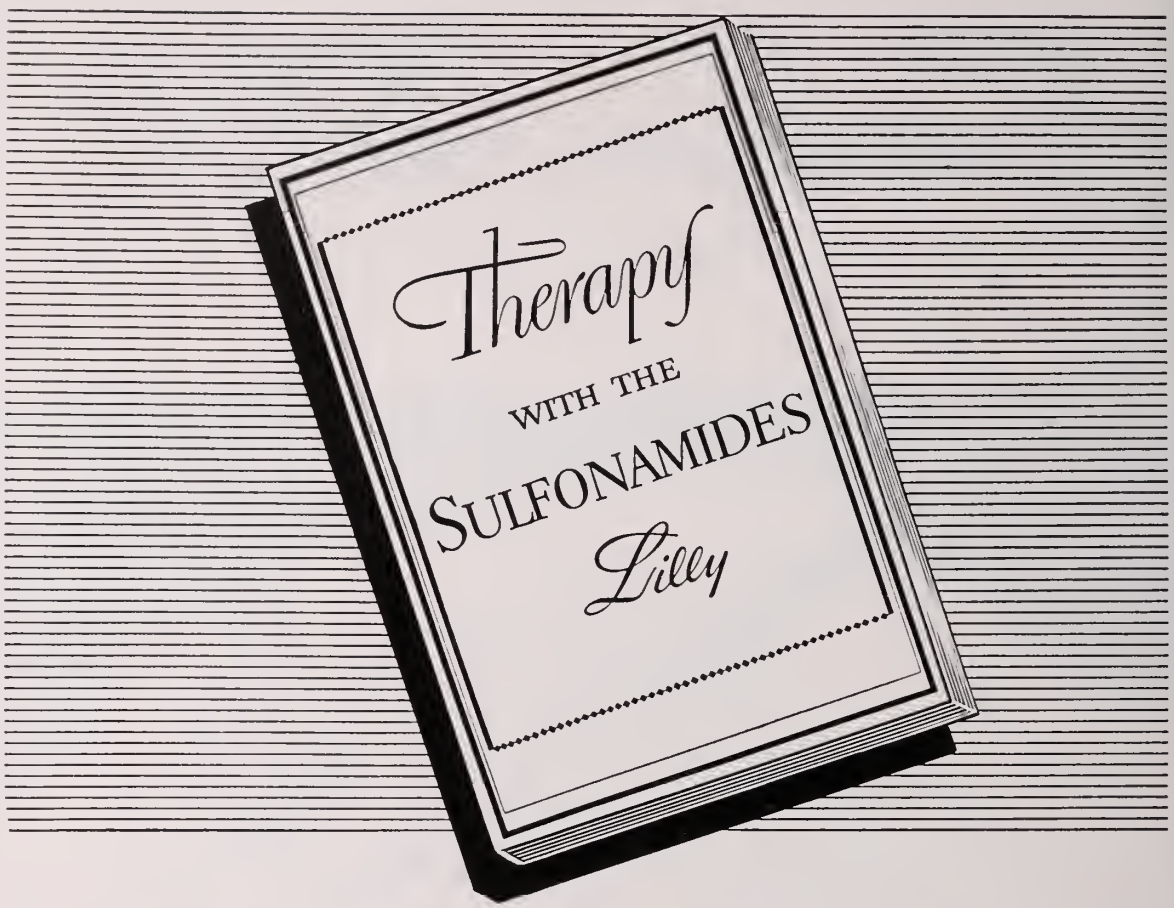
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Equal to any emergency

EVEN during his infrequent intervals of relaxation the physician's professional services are likely to be in demand. Young athletes require care that only a competent authority can provide. Prompt attention to a bruised knee, a sprained wrist, or a twisted ankle may prevent serious damage. And so it is that the physician often may be found in the stands at a baseball game, in the gallery at a tennis match, or on the bench at a football contest, prepared for any emergency that may arise.

The manufacturer of drugs and medicines also renders a service peculiar to him alone. During ordinary times his task is none too difficult, but he must be prepared to meet any emergency. In times of stress, production must be increased, distribution accelerated. During the recent horrifying crisis that engulfed the world, demand for new and better biological agents, improved pharmaceuticals, and blood plasma reached an unprecedented high. Eli Lilly and Company is proud of the fact that it was able to respond to wartime demands in full measure, without imposing serious inconvenience on civilian physician, pharmacist, or patient. Remaining shortages are rapidly disappearing.

A picture of The Good Samaritan provided the inspiration that



eventually led to the founding of Eli Lilly and Company

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BACKGROUND AND HIGHLIGHTS OF THE RHODE ISLAND HOSPITAL UNIT IN THE CHINA-BURMA-INDIA THEATRE OF WAR*

IRVING A. BECK, M.D.

The Author. *Irving A. Beck, M.D., of Providence. Assistant Physician, Outpatient Department, Department of Medicine, Rhode Island Hospital. Major, U. S. Army Medical Corps. (Inactive)*

"AN Evacuation Hospital is usually located 25 to 50 miles behind the front lines, receives patients from divisional clearing companies and medical battalions, has a 750 bed capacity, and does not keep patients over 7 days". So we were lectured in our training period in the United States in the Fall of 1942. We lived to see every statement disproved in so far as the 48th Evacuation Hospital was concerned. In actual experience, in the India-Burma Theatre, our hospital functioned at times as close as 15, at other times as far as 1500 miles from the front line; patients arrived from more sources than any technical manual enumerates; the number of beds ranged as high as 1900 and usually averaged well above 750; and certainly, in so far as Chinese patients were concerned, the length of stay in our hospital was limited only by the degree to which we became fed up with them. At times the hospital could have qualified as a station hospital, at others as a general hospital, and at still others as truly an evacuation hospital, but in general, performed the functions of all three. Not merely did the hospital itself assume a varied and unanticipated role, but its members found themselves assigned to projects and positions in nowise related to their T. O. capacity in the S. O. P. Evacuation Hospital, and indeed even more at variance with their civilian occupations.

The strategy which led to the assignment of American service units to the China-Burma-India Theatre is now well known. Briefly, it was the American mission in that theatre to open up a life line to China, — the Ledo Road, its accompanying pipe lines, and meanwhile, until those projects were completed, the carrying by air of needed supplies over the dreaded Himalayan Hump. This project involved the coordinated efforts of American, British, Indians, and Chinese. For the lack of coordination that occurred not infrequently, one may refer to the recent "Wrath in Burma" by Fred Eldridge. One can then get some idea of the administrative problems involved for our hospital when patients were drawn from all the foregoing nationalities.

When in March 1943 the 48th Evacuation Hospital finally arrived in the staging area (actually a patch of semi-cleared jungle) at Margherita in Assam, India, close to the unpenetrated mountain range that separated Assam from Burma, the Unit was disappointed to find that our Evacuation Hospital was, at least temporarily, surplus. The Base Commander however, found in the Unit a source of personnel for various missions and assignments which had gone begging for men. It is impossible to enumerate all the individual assignments. Some that eventually transpired were, — officers to go with the advance parties laying the trace for the Ledo Road. The Chinese Army had no medical department worthy of the name, and so the unusual post of Medical Liaison Officer was created, and some of our officers found themselves in this frequently unpleasant assignment. Their function was to supervise and teach Chinese Medical personnel, treat patients, and above all check misappropriation of Lease-Lend medical supplies. Hospital sites for the Seagrave Unit had to be laid out in the jungle no-man's-land ahead, and for this mission a group of our men volunteered. Another assignment that materialized was that of providing medical care for Chinese troops in training in central India, and for this purpose a large contingent of our officers and nurses was selected. Another group was assigned

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to the then mysterious "Rice Mission". This group had as its assignment, the taking of 200 Chinese and 200 American troops into highly malarial areas, and then permitting malarial exposure under campaign conditions, in order that a new anti-malarial prophylactic might be evaluated. The group ran into all kinds of practical difficulties, the greatest of which was the administrative handling of the Chinese. The group, however, eventually, accomplished its mission.

Later in the year, medical care was required for troops on and in advance of the Ledo Road, and for this purpose a detachment of our officers and enlisted men ran a Field Hospital which eventually grew to 300 beds, and rendered definitive medical and surgical treatment.

Meanwhile, the detachment at Ramgarh in central India, was accomplishing its mission of getting debilitated and diseased Chinese recruits into physical shape to pursue the Burma campaign, which, incidentally, had bogged down. In the spring of 1944, practically the entire group was reassembled near Ledo and a triple-combination-type hospital, already referred to, was established for Chinese troops. The Hukawng Valley campaign was now in dead earnest, and the hospital quickly became busy with large numbers of surgical and medical casualties. One of our officers took a detachment of our enlisted men with Merrill's Marauders in their sweep behind the Jap lines. After 6 busy months here, the entire hospital and its equipment, including even the 2½ ton trucks, were flown over the mountains into Myitkyina (pronounced "Mitchina") in upper Burma. This area had been just recently cleared of Japanese, and stragglers were still being rounded up. Here another triple-combination-type hospital was set up in a teakwood forest on the Irrawaddy river for American, British, Chinese, and Indian troops, for Kachin Rangers under the direction of the OSS, and for such native civilian Kachins, Shans, Burmese, Indian, and Chinese refugees as needed medical attention. The Unit continued to function in this area until the late Spring of 1945, when most of the personnel was returned to the United States under the two year rotation plan and the original Rhode Island Hospital component no longer existed in the 48th Evacuation Hospital.

In a brief summary such as this, one can touch only on the high-lights of two and a half years that were crowded with experiences, — medical, military and ethnic. Drab, uncomfortable, and monotonous though it often seemed at the time, now in retrospect the period in India and Burma is appreciated to have been not merely a contribution to the War effort, but a rich personal adventure.

OVERSEAS EXPERIENCES WITH THE MEDICAL SERVICE OF THE 48th EVACUATION HOSPITAL*

FRANK B. CUTTS, M.D.

The Author. *Frank B. Cutts, M.D., of Providence, Assistant Physician, Department of Medicine, and Associate, Department of Cardiology, Rhode Island Hospital. Lt. Colonel, U. S. Army Medical Reserve Corps.*

IN the time available I shall be able to present only a very sketchy panorama of our medical experiences in the China-Burma-India Theatre. After a few remarks of a general nature I shall briefly discuss some of the diseases we saw and treated together with figures indicating their appropriate incidence in our medical experience.

General Comments. Through a 2 year period ending June 30, 1945, our hospital admitted slightly more than 37,500 patients. About 7,500 of these were Americans, 2,000 were Indians, and the remaining 28,000, Chinese. Approximately two-thirds of the above patients were treated by the Medical Service as disease consistently produced more disability than did injuries or battle casualties, except for a short period during the campaign for Myitkyina. During our first year a large portion of our patients were Chinese recruits, freshly brought in by air from China. They were poorly nourished, suffering from beriberi, dysentery, relapsing fever, and heavily infected with malaria which they had contracted en route. They had no conception of sanitation and were constantly spitting on the floor until we could appeal to their sporting instinct to try and hit tin cans provided for the purpose. Flush toilets were available in most of our Chinese wards, but no one ever sat on them; the patients would invariably climb up on the seat and squat in oriental fashion with their feet on the rim, a feat that required a considerable degree of equipoise. After a few months we learned sufficient Chinese to take a

*Presented before the Rhode Island Medical Society at its 135th Annual Meeting, at Providence, May 16, 1946.

brief history and conduct a physical examination without the aid of interpreters.

Malaria. Our total reported cases numbered 6378. There were 1639 cases of Vivax malaria, 1193 in Chinese and 446 in Americans; 3502 cases of Falciparum malaria, 3383 in Chinese and 119 in Americans; 1191 cases in whom the diagnosis of malaria was made on clinical grounds alone, many of these patients having received anti-malarial drugs prior to hospital admission; 42 cases of mixed infections, almost always vivax and falciparum infection occurring together; and only 4 cases of infection with quartan malaria. There were 103 cases recorded as cerebral malaria, all except one in Chinese, and all with plasmodium falciparum demonstrated in the blood smear. We did not see cerebral malaria associated with vivax infection. Quinine intravenously has real dangers and we have witnessed convulsions and sudden death during its administration in spite of all recognized precautions as regards time of administration and dilution of the drug with saline.

Bacillary Dysentery. There were 2,356 cases of dysentery excluding amebic infection. In most of those in whom rectal swab cultures were obtained, various types of Shigella organisms were recovered. Almost all of these cases responded well to the administration of sulfadiazene, 2.0 Grams initially and 1.0 Gram three times a day for 5 days. On this regime there were no renal complications.

Amebic Dysentery. Proven cases numbered 653; 320 in the Chinese and 333 in the Americans. Thus it is evident, in view of the fact that we had about four times as many Chinese patients as Americans, that amebic dysentery was relatively much more common in the Americans. This probably represents a relative lack of immunity to this infection on the part of Americans, as it certainly cannot be maintained that the hygiene or the eating habits of the Chinese are less conducive to infection. There were a good many cases treated on clinical evidence alone in addition to the above group, so that we have treated well over 1,000 patients with emetine. There were no serious toxic effects from the drug, only occasional nausea and vomiting, muscle aches, slight weakness and rarely transient tachycardia on slight effort. However, it should be stated that in patients with significant debility we reduced the daily dose to ½ grain (0.03 Grams). The standard treatment used was emetine grains 1 daily for seven days and carbasone 0.25 Grams t.i.d. concurrently for ten days. We have had in our own detachment 20 proven cases of amebic dysentery, treated by this regime and observed for the following periods; 18-24 months — 12 cases; 12-18 months — 1 case; 6-12 months — 5 cases; 0-6 months — 2 cases. At a recent examination of this group all were symptom free and examination of two or more stools in each instance was negative. It should be emphasized that in each instance treatment was instituted early in the disease. From these figures and our experience in general we believe that the course of treatment outlined above produces good long term results in the great majority of cases.

Common Respiratory Diseases. This includes nasopharyngitis, rhinitis, bronchitis and tonsillitis. There were 2072 cases so listed.

Venereal Diseases. There were 521 cases of syphilis, largely in the Chinese. Among these were 2 cases of syphilitic meningitis, 2 of aortic aneurysm, about 20 of bone and periosteal involvement, and about 15 cutaneous gummas. There were 236 cases of gonorrhea, almost all in the Chinese, as Americans with this disease were treated on an outpatient status. Between 5-10% were resistant to sulfadiazene therapy but would sometimes respond to a repeated intensive course. Penicillin was not available for use in Chinese with this disease. Cases of chancroid numbered 179. Response to sulfadiazene orally and locally was good. There were 62 cases of lymphogranuloma inguinale, mostly in the Chinese except for a few American negroes. A few cases had generalized adenopathy, splenomegaly and high fever. Response to sulfadiazene was usually good although 10 or more days of treatment was often required.

Fever of Undetermined Origin. 509 cases were in this classification. A considerable portion of these cases were undoubtedly malaria or dengue-like fevers.

No Disease Diagnosed. 3,079 cases were so diagnosed. It was a not uncommon custom among the Chinese, as confessed to us on several occasions, to seek the rest, good food and sociability provided in the hospital when their duties became too arduous or boring. Many of the Americans so diagnosed had minor functional complaints that did not seem to us to justify a diagnosis of psychoneurosis.

Relapsing Fever. In this group were 438 cases, all but one in Chinese. Although heavy spirochaetal infections could produce severe symptoms with dehydration, jaundice and shock, treatment with moderate doses of Neoarsphenamine (0.3 Grams) intravenously usually produced striking improvement in 18 to 36 hours, the temperature frequently falling in this interval from 106 to 96 degrees.

Scrub (Mite) Typhus. 290 cases were so diagnosed, 169 in the Chinese and 121 in the Americans. This was the most uniformly severe disease that we encountered in either race and affected each with almost equal severity. Our experience coincided with published descriptions.

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Louse Borne Typhus. There were about 300 cases of this variety, all in the Chinese. The disease occurred in troops fresh from China who were lousy and who had a high incidence of concomitant relapsing fever. OX-19 agglutinations were usually high in this group. In general these patients were distinctly less ill than those with mite typhus and the mortality was about one-half as great.

Tuberculosis. There were 217 cases, all in Chinese. There were at least 5 cases of miliary tuberculosis. Due to the common habit these people have of spitting anywhere at most any time, opportunities for infection are legion, and their resistance to this disease is rather poor. In addition to the above, there were 96 cases of pleurisy with effusion among the Chinese, presumably of tuberculous etiology.

Asthma. 90 cases were found among the Chinese and 30 among Americans. In the Chinese the disease is frequently severe and intractable and so far as we could tell, non-seasonal.

Pneumonia (Broncho and Lobar). 270 cases fell in this category. There were no unusual features and they responded quite uniformly to sulfonamides. Clear cut primary atypical pneumonia was distinctly uncommon in our experience.

Psychosis. 159 cases were so filed, chiefly in the Chinese. There were probably more as, due to language difficulties, only those cases were included with grossly abnormal behavior. Many of these cases were wildly disoriented and so were promptly evacuated after the liberal use (15-20 cc. at a time) of intramuscular paraldehyde.

Heart Disease. There were 78 cases mostly in the Chinese. There were a few instances of congenital and syphilitic heart disease, but the great majority of cases were typical examples of old inactive rheumatic heart disease, with mitral stenosis by far the most common lesion.

Mumps. 160 cases were seen, all but one or two in the Chinese. There was the usual incidence of orchitis but no definite encephalitis. Cases were sporadic and there was no clear cut epidemic.

Beriberi. 226 cases in Chinese occurred early in our experience in troops fresh from China. Peripheral neuritis, edema and definite cardiac findings were the chief features observed, with a few dying in sudden heart failure. Response to Vitamin B by mouth or parenterally, as the need dictated, was good but often took several days before noticeable improvement occurred, the signs of neuritis persisting for several weeks.

Dengue. At least 60 cases were seen. The disease in general conformed to test-book descriptions, although there were many other cases with atypical fever of five to seven days' duration that may well have been instances of this disease.

Heat Stroke and Exhaustion. 65 cases were seen in a relatively short period when new Chinese troops were being drilled in the hot semi-tropical sun. Some of them came in with temperatures of 109-110 F., and a few expired before treatment could be instituted. Intravenous infusions of saline and cold wet packs applied under an overhead fan usually relieved symptoms and signs promptly. It is of incidental interest that at that period great care had to be taken in the use of clinical thermometers. If the thermometer was taken out of the alcohol solution and exposed to the room air for much over 15 seconds, it would register 105-106 from the intense environmental heat. The ward personnel developed the technic of taking the thermometer out of alcohol, quickly wiping it once with cotton, inspecting the reading and then popping it in the patient's mouth, shaking down the thermometer after use.

Typhoid Fever. 74 cases were seen, all in the Chinese. The disease varied from mild to very severe. We had one patient who maintained a high fever for 84 days before final recovery. In several instances, blood cultures were still positive after 40 days of illness. There were, in addition, a moderate number of paratyphoid and salmonella septicaemias.

Nephritis. 18 patients were so diagnosed, all in Chinese. The nephrotic stage of chronic glomerular nephritis was most common.

Cholera. 12 examples of this disease were seen among the Chinese and the Indians. Intense dehydration and shock with typical rice water stools were the clinical features and the response to massive (up to 8000 cc. daily) amounts of intravenous saline solution was uniformly good.

Generalized Vaccinia. 10 examples of this condition were seen, all in Chinese. There was very little constitutional reaction. The discrete pustular rash was generalized but considerably more intense about the site of the recent vaccination, often with secondary implantations following scratching.

Smallpox. 4 cases were seen, 3 in Chinese and 1 in an American. One was moderately severe, but all recovered. The American had the scar of a vaccination in childhood, but reported that subsequent vaccinations did not take, and presumably inactive material was used.

Tetanus. 3 cases were seen, all in Chinese. They did well on massive (400,000) doses of antitoxin intravenously and heavy sedation with barbiturates.

Leprosy. 3 cases were seen among the Chinese, one with rather extensive neural involvement and two with skin manifestations alone.

Skin Diphtheria. 5 cases, all in Americans, were seen while we were in Burma. Two of these had typical peripheral neuritis. The typical skin ulcer

was covered by a black adherent scab, and on healing left a thin atrophic scar.

Kala Azar. 4 examples of this disease were seen in the Chinese, all proven by sternal aspiration. 3 had positive Formol-Gel tests, one did not. All responded to treatment with intravenous injections of urea stibamine or neostibamine (antimony preparations), although one developed reactions consisting of nausea, vomiting and diarrhea and severe muscular pains, and another required two full courses of 3.0 Grams each before recovery. It is of some interest that in one patient the serum protein was 12 Grams, 9 Grams of this consisting of globulin.

Dermatitis. Although we do not have accurate figures on their actual incidence, skin diseases were common in both Chinese and Americans. In Chinese the commonest lesions were scabies, fungus infections, dermatitis venenata and secondary pyodermas. In Americans, epidermophytosis, tinea corporis, furunculosis and infectious eczematoid dermatitis were the most prevalent. This last condition was at times a serious cause of disability, and although 5% Ammoniated Mercury and penicillin locally would help temporarily, recurrences were all too common.

Cirrhosis. 22 instances of this condition were observed, all in the Chinese. There may have been more as the diagnosis was reserved for those with the full blown picture with obvious ascites, except in cases proven by autopsy. From stool examinations, and, in a few instances, microscopic sections of the liver, we found no evidence of causal parasitic infestation of the liver with such conditions as Schistosomiasis. We suspected that one factor might be the relative lack of protein often observed in the Chinese diet. Several of the patients with cirrhosis were in their early twenties.

Giardiasis. Giardia lamblia were found frequently in stools, often in patients with no symptoms. Their presence made us suspicious of amebic infection, as they and endameba histolytica were rather often found in the same stool specimen. One point of incidental interest is that giardia were often found in the stools of patients who had just completed a full course of atabrine for malaria, thus indicating that this drug is far from a sure cure for infestation with this parasite.

Ascaris and Hookworm. Ova of either or both of these parasites were present in at least 50% of stools in the Chinese. Ascaris was occasionally found in Americans and hookworm was fairly common, especially in Americans who had lived in fox-holes under combat conditions. Early in the infestation, especially if heavy, patients with hookworm would have an intense eosinophilia and rather severe upper abdominal discomfort. Treatment with tetrachlorethylene (3cc.) would reduce the parasite density and relieve symptoms, but in some patients hookworm ova remained in the stools even after 3 courses of therapy.

Arthritis. A few instances of typical gonorrheal arthritis were seen as well as an occasional instance of definite rheumatoid arthritis in the active stage.

Miscellaneous. It is of some interest that we saw only one case of diabetes, and that was in an Indian. In the Chinese we did not observe a single instance of cardiac infarction, although a fair number of our patients were over 40 years of age. Instances of malignant disease were limited to 4 cases of lymphoma, all in the Chinese. Secondary anemia was common but no instance of pernicious anemia was seen. No clear cut example of scurvy was encountered. A few cases of duodenal ulcer were seen, chiefly in Americans, but our facilities did not permit much in the way of gastro-intestinal studies. There were a few colloid goitres and non-toxic thyroid adenomas.

Summary

In this two year period we had a wide and varied experience with infectious disease, deficiency states and tropical disease.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACTS OF CONGRESS OF AUGUST 24, 1912, AND MARCH 3, 1933

of *Rhode Island Medical Journal,* published monthly at Providence, Rhode Island, for October, 1945.

State of Rhode Island } ss.
County of Providence }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Peter Pineo Chase, M.D., who, having been duly sworn according to law, deposes and says that he is the Editor-in-Chief of the *Rhode Island Medical Journal* and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Act of March 3, 1933, embodied in section 537, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Rhode Island Medical Society, 106 Francis Street, Providence, R. I.; Editor, Peter Pineo Chase, M.D., 106 Francis Street; Managing Editor, John E. Farrell, 106 Francis Street, Providence, R. I.

2. That the owner is Rhode Island Medical Society, 106 Francis Street.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

PETER PINEO CHASE, M.D., *Editor-in-Chief*

Sworn to and subscribed before me this 16th day of September, 1946.

JOHN E. FARRELL, *Managing Editor*
(My commission expires June 30, 1954

[SEAL.]

OVERSEAS EXPERIENCES WITH THE SURGICAL SERVICE OF THE 48th EVACUATION HOSPITAL*

J. Murray Beardsley, M.D.

The Author. *J. Murray Beardsley, M.D., of Providence. Associate Physician, Department of Surgery, Rhode Island Hospital. Major, U. S. Army Medical Reserve Corps.*

Two factors influenced the surgical work of the 48th Evacuation Hospital during its overseas tour of duty; the first, that we were in a tropical country and second, that for the most part our patients were Chinese troops.

It will readily be appreciated that in temperatures of 120 degrees or more and with a relative humidity of between 80 and 90 the problem of fluid balance was a major one. This was complicated by the fact that during the early days prepared intravenous solutions were not available and that there was increased fluid loss from the necessary use of mosquito bars.

In the beginning our surgical equipment was inadequate, to say the least. For example no anesthetic machine or suction apparatus were available except what could be improvised. As time went on, however, we received our full quota of surgical supplies.

The difficulties encountered in the use of ether, and other anesthetic problems are well covered by Dr. Edward Demarjian, chief anesthetist, in his paper "Anesthesia in the Tropics," R. I. Medical Journal, September, 1944.

Since the Chinese Army had no chain of evacuation for the handling of patients, as was so with American troops, our unit for the most part acted as a general hospital. It was, therefore, possible to follow our patients through and to carry out various types of definitive surgery such as plastic reconstructive surgery, bone grafts, etc. This added much to the interest and to the enjoyment of our work.

In an attempt to cover a few of the highlights in the brief time allotted I will divide my time into three sections and speak briefly on 1. Some aspects of tropical surgery 2. The treatment of battle casualties 3. Illustration of surgical cases with lantern slides.

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Some Aspects of Tropical Surgery

a) In dealing with surgical cases under any conditions it is always wise to keep in mind that the origin of fever may not be due to the actual operation. The Chinese and Indian patients that came under our care were to a considerable extent infested with various types of parasites which frequently came to life following surgical procedures. Malaria was the chief offender but other diseases such as kala azar, relapsing fever, dengue, the dysenteries, etc. were not infrequently at fault. Blood smears and stool examinations were routine in all cases with elevation of fever.

b) We had barely arrived in India when we were warned by the British against drainage of amoebic abscess of the liver which they stated resulted in almost 100% mortality. We, therefore, did not have to learn the hard way that conservative treatment with emetin, and occasionally aspiration, was the procedure of choice, except where secondary infection and non-response to the medical regime occurred.

We did, however, have two cases of rupture of amoebic abscess into the peritoneal cavity with symptoms and signs suggestive of ruptured peptic ulcer. The characteristic anchovy sauce type of pus was observed. Both of these cases made a prompt and uneventful recovery and I have a feeling that this experience made some of us question the dangers of open drainage, although this was entirely unjustified with only two cases upon which to base our opinion.

c) Because of the very high incidence of splenic enlargement due chiefly to chronic malaria we had a rather large experience with injuries to the spleen and had 18 cases of rupture that required spleenectomy. This not infrequently occurred from a relatively minor injury such as falling down or being struck by a fist. The following types of injuries were observed:

1. complete fragmentation
2. radial lacerations which usually extended into the pedicle
3. complete division of the lower pole
4. subcapsular hematoma
5. secondary hemorrhage occurring several days after a minor injury

Time will not permit a discussion of the symptoms, physical signs and differential diagnosis of the various types of injury although these are of interest. I would like to speak for a moment about the technique of operation. All patients were operated upon as soon as the diagnosis was made and had received adequate pre-operative preparation which is necessary in all cases of hemorrhage. The aim was to control bleeding as rapidly as possible. The left subcostal incision was superior in our hands. The left rectus incision on more than one occasion led to difficulties and had to be augmented by an additional transverse incision.

A "T" incision was used occasionally but took more time both on opening and closing. As soon as the peritoneal cavity was opened the pedicle was immediately grasped between the thumb and finger or by a rubber covered clamp. The next step was to clear all blood from the peritoneal cavity which was used immediately for autotransfusion. Proper walling off was then carried out and the operation continued in a more leisurely fashion, dividing the ligaments and dissecting the pedicle. It should be borne in mind that these spleens were very large which added to the difficulties of operation. Two deaths occurred, one from uncontrollable hemorrhage on the table and one from post-operative shock.

d) A disease which caused a very high morbidity, chiefly among Chinese and Indian troops, was tropical ulcer. This lesion is of unknown origin although many theories have been advanced. It is a chronic, sloughing, undermining ulcer, most frequently seen in the lower legs, the bony prominences of the mallolei and the dorsum of the foot being most commonly affected. The organisms that are usually recovered are B fusiformis or spirocetes or both. These ulcers tend to occur in the debilitated and malnourished although this is not always the case. They may be single or multiple.

Seagrave recommended the use of 10% saline in glycerin combined with debridement. We found this method on the whole unsatisfactory and had the opportunity to observe some of his cases that had been under treatment for several months, when we took over the hospital at Ramgarh. Our best results were obtained by immediate excision of the ulcer followed shortly by split skin grafts. This resulted in a marked shortening of the period of hospitalization and early return to duty. The work of some of our earlier cases was published in the C. B. I. Medical Bulletin.

e) Because of the prevalence of diarrhea due to dysentery, prolapse of the rectum was a common complaint. It was seen in all stages from a slight mucosal prolapse to a protrusion 6 inches or more in length sometimes with strangulation.

In general three operative procedures were carried out. 1. In the mild form radial excision of the mucous membrane of the lower rectal segment was effective. 2. In the second degree prolapse this relatively minor procedure was not adequate. The rectum was exposed through a posterior incision and the wound packed open with plain gauze and allowed to granulate. This inflammatory reaction had the effect of freezing the segment in its normal position. In some instances a combination of 1 and 2 were carried out. 3. For a third degree prolapse which is essentially an intus-susception of the upper segment, the above operations were of course not indicated. Cure was only affected by a transperitoneal approach with mobilization of the recto-sigmoid region, shortening of the transverse ligaments and obliteration of the pouch of Douglas by purse string sutures of silk or cotton.

f) We noticed a very definite lowered incidence of appendicitis among rice eaters. Although at times our hospital population reached 2,000 cases, acute appendicitis was a rarity in the absence of American troops. When we were caring for Americans the usual high incidence of appendicitis was immediately noted. I was told by one British physician who had been in Burma 15 years that appendicitis did not occur in Burmese. One must question the validity of this statement, but the very low incidence is certainly a fact.

The Treatment of Battle Casualties

Our work with battle casualties was confined chiefly to the Chinese although during our overseas stay we treated a fair number of Americans as well as Indians and British troops.

On the whole we found the Chinese to be good surgical patients who submitted readily to operative procedures which in almost every instance was something entirely foreign to them. I would be stretching the truth if I said they were all good post-operative patients although I would say it without malice. The fact that they were not was due rather to their native curiosity and inquisitiveness than to maliciousness. They removed dressings to determine what lay beneath and cut off casts with their pocket knives, sometimes for the same reason or to relieve some slight discomforts. They did not take their operations very seriously and solved the problem of thrombo-phlebitis by casually getting out of bed and walking about following their operation. We were inclined in a large measure to overlook these caprices because of their unfailing good humor. Surgical operations excited great interest and operations were never in progress day or night without every window of the operating room being filled with Chinese faces. Visitors came in swarms to visit their friends and spying

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empty beds promptly disrobed and spent the night and at times remained for days until a bed count revealed that there were many more beds occupied than there were patients in the hospital. It was also a common occurrence to discharge patients in the morning and to find them occupying their bed that same night. In time most of these irregularities were overcome although stringent measures were sometimes necessary.

So much has appeared in the literature on the treatment of war wounds that anything that I can say is essentially repetition. In general our experience paralleled that of others very closely. At Ledo when we were receiving casualties from the North Burma campaign, our population was between 1,500 and 2,000. All cases were air borne, flying at a maximum altitude of about 10,000 ft. The majority of these cases had had debridement of their wounds before arrival but when the pressure of work was heavy in the forward areas casualties were flown back to us for their initial treatment.

Chest Wounds

We received about 250 perforating and penetrating wounds of the chest. At Ledo we treated 189 cases and detailed statistics were kept. It might be of interest to record some of these figures.

Bullet wounds	95
Shrapnel wounds	88
Bayonet wounds	2
Uncertain	4
	189
Wounds of the right chest	108
Wounds of the left chest	79
Wounds of both chests	2
	189
Abdominal-thoracic wounds	
Right chest	7
Left chest	8
	15

The pathology existing on arrival at our hospital was at follows:

Pneumothorax	19	(7 with tension)
Hemothorax	43	(2 with tension)
Hemo-Pneumothorax	36	(8 with tension)
Hemorrhagic Pneumonitis	78	
Negative Findings	13	
	189	

In this group 22 developed empyema and required drainage. There were 9 deaths, the majority being due to shock, which in most instances resulted from too early evacuation following serious injury or major operations in the forward area.

When dealing with accumulations of air or blood in the pleural cavity the chief aim of treatment was their early removal and rapid re-expansion of the lung. Other methods tend not only to impair normal lung volume but also to delay healing and prolong convalescence. This is a relatively old principle but the war experience brought it more forcibly to the attention of the rank and file of surgeons.

Although a large number of retained foreign bodies in the lung were observed only four required surgical removal. Our criteria for removal of foreign bodies from the lung may be summarized as follows:

1. Asymptomatic: Large foreign bodies lying near the lung root should be removed because of the danger of severe secondary hemorrhage.
2. Symptomatic: The following symptoms occurring either alone or in combinations necessitate surgical interference.

a. Persistent hemoptysis.

b. Persistent chest wall sinus.

c. Recurring localized attacks of pneumonitis in the region of the foreign body.

d. The development of a frank abscess.

The most important part of the surgical procedure is accurate localization. The actual operation is essentially a simple undertaking.

In our entire series we had no wounds of the heart or pericardium. Our one case of mediastinal abscess recovered.

We have nothing to add to the already voluminous literature on gunshot wounds of the abdomen except perhaps to re-emphasize the importance of exteriorization of wounds of the colon and calling attention to the great hazards associated with wounds of the rectum not early and properly treated by obstructive colostomy as an emergency measure, in addition to local debridement.

The wound of entry was occasionally misleading. For example we observed missiles entering the arm which traversed the pleural cavity and wounds of entry on the thigh not infrequently involved the peritoneal cavity.

Gas gangrene was usually associated with injury to the main arterial supply of the limb and in the early days circular bandages applied to dressings beneath a cast was a strong contributing factor. In cases where gangrene was present as a clinical entity, not merely by positive cultures, surgery was the only valuable weapon although serum, x-ray, and chemiotherapy were also utilized. As a rule amputation was required but in an occasional case the removal of entire muscle groups sufficed.

NOTE: *Illustrative lantern slides of surgical cases were shown.*

EXPERIENCES WITH SYMPATHECTOMY*

JESSE P. EDDY, III, M.D.

The Author. *Jesse P. Eddy, III, M.D., F.A.C.S., of Providence. Senior Assistant Visiting Surgeon, Memorial Hospital, Pawtucket; Assistant Surgeon, Out-Patient Department, Rhode Island Hospital.*

FOR the purposes of this paper, the discussion will be limited to the thoraco-lumbar (sympathetic) division of the autonomic nervous system, and to three distinct types of surgical procedures upon this system; namely—lumbar sympathectomy and thoracic sympathectomy for peripheral vascular disease, and thoraco-lumbar sympathectomy with splanchnicectomy — the so-called Smithwick procedure — for essential hypertension.

Definition of sympathectomy: Sympathectomy may be defined as that surgical procedure upon the sympathetic nervous system whereby a portion of the trunk with one or more ganglia are removed.

Historical background: Galen in the second century was the first to refer to the sympathetic nervous system. He was the first to describe the paravertebral sympathetic chain with their several ganglia. J. B. Winslow, the Dutch anatomist in 1732, gave the name "sympathetic" to nerves which he dissected and found to lie without the main cerebral spinal paths. Francois Petit in 1727 made the discovery that the sympathetic trunk originated beneath the skull, and not from the brain itself, as previously thought by Galen and all subsequent anatomists. The detailed anatomy of the autonomic nervous system was first established with the improvement of the microscope and the development of the microtome in 1870 by His. Alexander of Liverpool, in 1889, was apparently the first surgeon to operate upon the sympathetic nervous system. He did a cervical sympathectomy for epilepsy. Others tried this same procedure, but the results were not strikingly successful, and surgical interest temporarily died away. In 1916 a Rumanian surgeon operated upon the cervicothoracic sympathetic nerve in an attempt to relieve the pain of angina pectoris. His first case was brilliantly successful and was the beginning of modern operations for the relief of anginal pain. Leriche of France, in 1913, first called attention to the increased flow of blood in the extremities in peri-arterial sympathectomy. Hunter and Royle in 1924 accidentally discovered that, on sectioning the sympathetic rami of the lumbar trunk, there was a coincident vasomotor paralysis of the extremity on that side with a striking increase in the circulation. This observation has led to the present surgical treatment of Raynaud's disease and other vasospastic disorders by sympathectomy. This operation began to be performed more commonly in this country around 1930, and since that time has dug out a very definite niche for itself in the treatment of peripheral vascular disease.

In the treatment of essential hypertension by sympathectomy, the possibility of a surgical approach was first discussed by Kraus in 1923. In 1930, the first actual splanchnic resection for hypertension was performed by Pieri, and, in that same year, Adson of the Mayo Clinic tackled the problem by a laminectomy and anterior root section, later reporting his technique. Craig (1934) reported a sub-diaphragmatic operation on the splanchnic nerve and Peet (1935) a supradiaphragmatic approach to the same nerve. Celiac ganglionectomy was later advocated by Crowe. Smithwick of Boston has had an experience with a number of these operations since 1935, and now practices a combined supra- and infra-diaphragmatic approach which he has used since 1938. Recently Grimson of North Carolina has advocated a more extensive thoracolumbar sympathectomy and splanchnicectomy, his bordering on almost total thoracolumbar sympathectomy.

Anatomy: The autonomic nervous system may be divided into two main anatonomical and functional divisions, namely, the sympathetic or thoracolumbar outflow which springs from the spinal cord over its anterior roots between the first thoracic and second lumbar segments, and the para-sympathetic or cranial sacral division. The vagus nerve contains the major portion of the para-sympathetic fibers, but others are also present in the oculomotor, facial, and glossopharyngeal nerves. The sacral para-sympathetic nerves leave the spinal cord with the second, third and fourth sacral nerves in the corda equina. It is our purpose here to concern ourselves with the sympathetic division of the auto-

continued on next page

*Presented at a meeting of the Pawtucket Medical Association, September 28, 1945, at Pawtucket, R. I.

nomic (involuntary or vegetative) nervous system, or those springing from thoracic nerves one to twelve and lumbar nerves one and two. The paravertebral ganglionated chain of the thoraco-lumbar division run on either side of the vertebral column from the base of the skull to the ganglion impar at the coccyx. The individual ganglia are pea sized, fibrous bodies connected together by the so-called sympathetic trunk, a definite structure slightly larger than the lead in an ordinary lead pencil which can be easily felt as well as seen. Branches from the spinal nerves connect with these ganglia, and branches leave the ganglia to supply the various viscera of the body. These chains are lying directly on the bones of the spine, just in front of the transverse processes in the cervical spine, over the heads of the ribs in the thorax, and on the anteriolateral surfaces of the lumbar vertebrae. Each chain has twenty-four ganglia, one for each spinal nerve except for the fifth lumbar, and for five of the cervical segments. These chains fuse in front of the coccyx, and the ganglion impar. In brief, each spinal nerve, as it emerges from its foramen, gives off a white ramus communicans to its corresponding sympathetic ganglion. These myelonated fibers originate in the lateral column of the spinal cord and from the ganglion gray rami of unmyelonated type go out to the visceral structures terminating in smooth muscles and glands throughout the body.

In lumbar sympathectomy where the first, second and third lumbar ganglion and connecting sympathetic trunk are removed, the nerve fibers running to the blood vessels, sweat glands, and hair follicles of the lower extremity on the affected side are interrupted, thus causing maximal vasodilation, the abolishment of sweating, and the inability of hairs to stand erect. No other significant effect is known in the female, but the male, when the operation has been done on both sides, the rhythmical contraction of the ejaculatory mechinism in coitus is lost, although libido erection, and satisfactory orgasm are still present.

In the thoraco-lumbar sympathectomy and splanchnicectomy operation of Smithwick, the thoracolumbar chain is removed from T-9 to L-3 inclusive taking the greater, lesser and least splanchnic nerves as well. This produces a preganglionic type of sympathectomy for all structures beneath the diaphragm bringing about the maximal vascular bed and thus reducing the blood pressure.

In conclusion then, the sympathetic nervous system innervates non-striated muscles, and glands which are not under the control of the voluntary nervous system of the cerebral cortex. These compose the pseudotory and digestive glands, the heart and blood vessels, as well as tubular viscera, such as, the oesophagus, trachea, bronchi and the gastrointestinal and genito-urinary tracts. Each of these structures as a rule received a dual innervation, one from the cranial sacral division of the para-sympathetic system, and the other from the thoracolumbar outflow of the sympathetic system, and these tend to oppose each other.

Physiology: Cannon in 1929 removed the sympathetic ganglionated chains in cats on both sides from the neck to the lower lumbar region. These animals who had undergone total sympathectomy were able to live in a sheltered environment in the laboratory in good health for many years. They became very sensitive to cold, and lost their ability to conserve heat. Erection of the hair was permanently lost. Ability to perform muscular work and to resist fatigue were considerably reduced. The digestion was unchanged. The heart rate was only slightly slowed. The metabolism was reduced approximately ten percent. These cats became pregnant and could reproduce in a normal manner, but were unable to nurse.

In conclusion, the sympathetic nervous system should be considered as an emergency safe-guard, not always operating, but ready to go into action when called upon. Such stimuli as pain, hemorrhage, asphyxia, infection, dehydration, extremes of temperature, intense emotion or psychic trauma may call it into action.

Under certain pathological conditions, this mechanism may cease to function properly. As an example, some people may suffer from chronic vasoconstriction, their hands and feet being constantly cold and moist from excessive perspiration. In others, the heart may speed up at the slightest stimulus, or food may not pass along the gastro-intestinal tract at a normal rate. When such conditions continue, we have the disease entities, such as, Raynaud's disease, neurocirculatory asthenia, cardiospasm, pylorospasm, megacolon, and many other vague symptoms without a definite diagnosis. By paralyzing the nerves which bring these conditions about, such pathological entities are now being brought under control.

Lumbar sympathectomy: Lumbar sympathectomy is the removal of the first, second, and third lumbar ganglia and connecting sympathetic trunk on one or both sides. It is the therapeutic procedure of choice in most cases of Raynaud's disease, Buerger's disease, arterio-sclerotic impending gangrene with or without diabetes, chronic ulceration of the extremities, vasospasm of nervous origin, hyperhidrosis of nervous origin, and thrombophlebitis.

When confronted with any one of the before mentioned diseases, certain simple tests can be utilized to determine whether or not lumbar sympathectomy or paravertebral injection of the lumbar sympathetic ganglion are indicated. Sympathetic activity is best judged clinically in an extremity by its ability to vary in temperature and

moisture. A leg or foot which on one day is relatively warm and pink, and on another cold and clammy white shows distinct evidence of hypersympathetic activity. All we can hope to accomplish by sympathectomy is abolishment of the vasospasm and sweating, and in an extremity where clinically we can find no evidence of vasospasm, we are gambling if we think to relieve it by sympathectomy. Certain tests have been devised which give an indication of whether or not sympathetic activity exists. These include skin temperature readings before and during spinal anesthesia or paravertebral lumbar injection, oscillometric recordings taken before and after paravertebral injection, sweating tests, foreign protein injection reaction tests et cetera. It can now be generally stated without reservation that most such tests are without great value for the simple reason that they are not sensitive enough to serve in the border line cases. Clinical judgment has once again come into the ascendency and here experience with many such cases is a telling factor. Suffice it to say that sympathectomy, or any other surgical procedure short of amputation, can not be expected to be helpful where gangrene has already set in, but in threatened or impending gangrene much can still be done. Then again there is a considerable difference in gangrene of a toe in Buerger's disease as compared with the same gangrene in a toe of an arteriosclerotic diabetic. In a Buerger's disease, which has advanced to the point of gangrene of the toe, one would expect the oscillometric recording to be generally zero from the knee down, but in the case of the arteriosclerotic diabetic, there might or might not be good major vessel pulsation even down to the ankle. Depending on the blood supply and whether there was any evidence of vasospasm, such as, slight changes in skin temperature and some evidence of moisture, one would decide on whether or not to do a lumbar sympathectomy. In fifty percent of the cases which appear hopeless, sympathectomy has been known to save the extremity or, at least, markedly postpone amputation, and do much for the relief of pain. One can always amputate a leg, but never put it back once removed so that, in case of doubt, a patient should be given the benefit of a sympathectomy if there is the least chance that it might be helpful.

The Operation: The operation itself is a relatively simple brief surgical procedure consuming approximately forty minutes to perform and confining a patient to bed only three or four days, and that in essentially complete comfort. The operation is performed under spinal anesthesia with the patient lying on the opposite side in the kidney position with the thighs flexed and the space between the superior crest of the ilium and the twelfth rib put on the stretch. A kidney type of incision is made in this region, the lumbodorsal fascia split, and the space lying in front of the quadratus lumborum and psoas major muscles developed until the lumbar sympathetic trunk can be seen and felt lying to the medial side of the psoas major on the anterior lateral surfaces of the lumbar vertebral bodies. It is then a relatively easy matter to resect the first three lumbar ganglia and trunk.

The effect of this procedure is immediate and permanent. The lower extremity on the affected side becomes dry and warm, and in cases where there had been previously marked vasospasm, the oscillometric recordings will increase anywhere from twenty to fifty percent. Even in severe cases of Buerger's disease, marked by cramplike intermittent claudication in the lower extremities, oscillometric recordings can be expected to improve surely but slowly over a period of many months, bringing to the patient that maximal circulation which can be expected to preserve the extremity. The operation itself carries with it no mortality and practically no morbidity. Such patients may be gotten up out of bed on the third or fourth day after operation, if desirable, and all of them will be more than grateful for the warm dry extremity and relief from pain.

Thoracolumbar sympathectomy and splanchnicectomy: Hypertension in man may be classified under five main groups, namely, endocrine, cerebral, cardiovascular, renal and the so-called essential or unknown group. Such diseases as chronic pyelonephritis, tumors of the pituitary or adrenal glands, coactation of the aorta, brain tumors, — all must be ruled out before a diagnosis of essential hypertension can be established. Essential hypertension, however, constitutes the largest group of all, and, as a cause of death, is several times more common than cancer. There is no known medical treatment yet discovered which can importantly affect the onward march of this dread disease. Suffice it to say that we do not know its cause, and there are many theories which have been evolved.

The history of the surgical treatment of this disease has been discussed. It is now no longer on an experimental basis. The so-called Smithwick procedure or thoracolumbar sympathectomy and splanchnicectomy is today recognized as the best surgical procedure for the relief of these patients. It is important to know, however, when the operation is indicated and when it is not indicated, and, because of mistakes along these lines, unfavorable cases have come to the attention of the medical profession.

Tests for determining operability: 1. The patient should have undergone a thorough medical workup which has definitely established the diagnosis of essential hypertension. 2. The response to the usual medical therapy should have been

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utterly unsatisfactory. 3. There should have been no permanent damage done to any of the vital organs for one cannot expect to significantly restore vital organs to normal by surgical procedures. 4. These patients in general should be under the age of sixty years although the numerical year is not as important as the physiological age. 5. The tests which are routinely done, at the present time, in addition to the above, to determine operability and to help in classifying the patient's condition and in estimating the prognosis, are as follows: a. Eyeground examination. This is very important as it classifies the patient's blood vessels and, hence, groups them into four different divisions. Group 1. Those with constricted changes in the retinal vessels only. Group 2. Those with constricted changes, and, in addition, tortuosity and nicking of the veins. Group 3. The above previous changes, and, in addition, exudate and hemorrhages. Group 4. In addition to the above, papilledema. Groups one and two are the favorable cases for operation, three borderline, and group four should be denied surgical help except in extreme instances, and, these, usually without success. b. The heart should undergo extensive investigation including x-ray studies and electro-cardiography. Significant permanent heart damage, especially with evidence of failure, is an unfavorable prognostic sign. c. The kidney function should be estimated including the routine urinalysis. Fishberg dilution concentration test, phenosulfothalin test, and intravenous pyelogram. d. The Sodium Amytal test or the giving of three grains of Sodium Amytal every hour for three hours estimating the blood pressure at the outset, and for eight hours, thereafter, on an hourly basis should show an ability of the blood vessels to relax with marked fall in pressure if a favorable outlook can be anticipated. e. The cold pressor test or the plunging of an upper extremity into a bucket of ice water and reading the blood pressure before and every thirty seconds for one minute, and then at minute intervals for three or four minutes should indicate an ability of the blood vessels to go into spasm with a prompt and immediate rise of both diastolic and systolic pressures considerably above the resting level dropping rapidly to normal again after withdrawal.

Satisfactory responses to these tests indicate a patient whose prognosis following such an operative procedure would be good.

The operation: Thoracolumbar sympathectomy and splanchicectomy, although a more major and complicated procedure than lumbar sympathectomy, nevertheless, carries with it a practically negligible mortality, but a definite period of morbidity. The same position of the patient on the operating table is used, the incision, however, extending upwards as high as the eleventh rib running parallel to the lateral border of the sacrospinalis muscle group after reaching the junction of this muscle and the twelfth rib. Intratracheal cyclopropane anesthesia is the one of choice because there exists the possibility of opening the pleura with consequent collapse of the lung unless this precaution is taken. The eleventh and twelfth ribs are resected and the space both below and above the diaphragm developed; the pleura being stripped away from the posterior thoracic cage, and the sympathetic trunk along with the splanchnic nerves identified. The sympathetic trunk is cut across at T-9 or T-10 and removed down to and including L-2 or L-3. The greater, lesser, and least splanchnic nerves are taken encourse down to their attachments into the various ganglia below the diaphragm. The operation is done in two stages ten days apart. It consumes approximately two hours, and the patients make a uniformly, surprisingly splendid convalescence usually being able to sit up on the fourth or fifth day following the first stage and on the eighth or ninth day following the second stage. After the second stage, steps must be taken to combat the postural hypotension which develops with the upright position. These include tight bandaging of both lower extremities, and of the abdomen using a pillow or rubber sponge pad in the latter region. The organism accommodates itself to this mechanism in one to four months when such precautions may be abandoned.

Thoracic sympathectomy: This operation has been done chiefly for Raynaud's disease, vasospasm of nervous origin or hyperhydrosis of nervous origin where denervation of the upper to correct this condition is indicated. It is the most difficult technically of the various types of sympathectomies which are done, but from the patient's standpoint is the easiest, the one most free from pain and morbidity.

With the patient lying in the prone position, anterior chest supported by pillows so that the shoulders and arms fall forward giving the maximum space between the medial borders of the scapulae, and with the head bent slightly forward so there are no wrinkles in the neck, and with no pressure on the abdomen, an eight centimeter incision centered opposite the space between the second and third thoracic spinous processes five centimeters lateral to the midline is made. The skin and subcutaneous tissues are cut through. The trapesius muscle split transversely, and the rhomboid muscle likewise split, and five centimeters of the third rib are resected including the tip of the transverse process. The third intercostal nerve is picked up at the lateral border of the incision, cut across and dissected up as far as the intervertebral foramen. The sympathetic trunk is located, and cut below the third dorsal ganglion, and turned upwards above the second dorsal gan-

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THE SURGICAL PLAN FOR RHODE ISLAND

IT IS with a great deal of pleasure that I, as President of the Rhode Island Medical Society, announce that the House of Delegates, policy-making body of the Society, at a meeting held on September 25, gave its wholehearted endorsement of the proposed voluntary prepaid surgical insurance plan that has been drafted by a steering committee of the Society and the Hospital Service Corporation, with the understanding that the service rendered under the program shall be by doctors of medicine.

From the very beginning of the study of a non-profit plan to aid the public in the better distribution of the costs of medical and surgical care the Society has taken active leadership. In accepting, under the proposed plan, the responsibility for the services to be given the subscribers the Society is deeply conscious of the tremendous obligation that it has to the public to see that the slightest standards of professional competence are maintained at all times. The House of Delegates is determined that that obligation shall be discharged to the best of our ability, and therefore it voted at the meeting this week that it requires that participating physicians in the plan shall be those licensed by the board of examiners in medicine under the laws of this state, and that non-participating physicians shall be those licensed by the board of examiners in medicine in this state, or in any other state by a comparable board of examiners in medicine.

For thirty years medical schools and hospitals have had to meet high standards set by the American Hospital Association and by the Council on Medical Education and Hospitals of the American Medical Association if they are to be approved institutions. Those standards must be maintained continuously, and even improved from time to time, if the recognition is to be retained. In addition, the medical profession from time to time established increasingly rigid requirements through specialty boards for the doctor of medicine who would qualify by examination and experience for rating as a specialist. All these programs have been carried forward in the best interest of the public. The Rhode Island Medical Society therefore has reserved the right to require that any service rendered the people of this state under a medical and surgical plan with which it is affiliated and for which it assumes definite responsibility, shall be in accordance with these high standards.

Ever since the former Governor, Honorable J. Howard McGrath, proposed to the Rhode Island Voluntary Advisory Council in April, 1944, that the Rhode Island Medical Society was the proper organization to devise a medical and surgical prepaid voluntary plan for this State, and that it should be given exclusive right to plan, organize and operate such a program, the Society has devoted much time and effort to the project. We are indebted to

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those of our own membership who gave unstintingly of their time and energy to work out details of the plan, as well as to the officials of the Hospital Service Corporation and the representative citizens who cooperated fully with us in our efforts.

It is to be recalled that after the words of encouragement from former Governor McGrath, and the statewide Advisory Council, the Society elected six of its members who in turn selected as lay members of the study committee Messrs. Roderick A. Pirnie, George C. Davis, and Charles Baker, all of Providence, Harold Amrhein of Woonsocket, and Ralph Kenyon of Pawtucket. This group accumulated much data on surgical plans then in operation in other parts of the country, and through their study laid the foundation for the plan now proposed. Their findings, recommending a close alliance with the Blue Cross plan to simplify the administration of the program, were accepted by the House of Delegates of the Society. This committee also prepared enabling legislation that the Society had introduced in the General Assembly a year ago which received the approval of that body.

Continued studies by a steering committee of the Society and of the Hospital Service Corporation resulted in the action by the House of Delegates whereby the Hospital Service Corporation was granted permission by the Society to change its Articles of Association to take over complete administration and operation of the plan. Prior to the granting of such permission, it was agreed that the board of directors administering the plan should have a medical representation on a ratio of one doctor for every four directors, and that the drafting of the schedule of indemnity benefits should remain with the Society.

The Society has elected its representatives to serve with the board of directors. A special committee has studied non-profit surgical plans throughout the country and has drafted the schedule of benefits for Rhode Island that is comparable to the average, thus assuring that our plan, in so far as is predictable at this time, shall operate at a minimum expense, even to the extent of reducing the payments to the participating physicians if the solvency of the fund is threatened.

If there are flaws in the proposed plan, time and experience will have to be our guides for correction of them. Certainly every effort has been made to present a workable non-profit voluntary program within the economic reach of every employed person in the state to aid him in meeting the costs of surgical care in and out of the hospital. We are confident that the medical profession of Rhode Island will give the plan complete support once it is finally approved by the board of directors of the Hospital Service Corporation.

HERMAN C. PITTS, M.D., *President*
Rhode Island Medical Society

September 27, 1946

HONOR FOR DR. BURGESS

Dr. Alex M. Burgess has just been made a member of the American Board of Internal Medicine.

There is a determined effort being now made in this country to put the practicing of the specialties on a higher plane. If this effort succeeds, as it apparently will, the result will be that in the not distant future only those men approved by the various boards will have any standing as specialists. Already the Board of Internal Medicine has gone a long way in achieving their desired results.

The Board of Internal Medicine was originated by the American College of Physicians in collaboration with the American Medical Association and consists of a dozen members. With the exception of Dr. Burgess these are all professors in great medical schools and, we understand, are nearly all heads of their departments.

Dr. Burgess has shown in the past that he is well qualified to fulfill the duties of his new position. Soon after graduating from Harvard Medical School and working under the late Dr. Mallory in Pathology, he held a professorial position in this department at McGill. As Chief of Staff in Medicine at the Rhode Island Hospital he has taken a leading part in the determined effort being made to advance the standard of work done by medical men at that institution. Thus, he has had much experience in teaching and the corollary of this, the examining of young men and the appraisal of their training and abilities which is the especial function of the Board.

We feel that he is unusually fitted to associate with leaders of the profession, and it seems especially valuable that the Board should have the viewpoint of a man working in a large community and a progressive hospital but still not in an environment of pedagogues.

We congratulate Dr. Burgess on the recognition he is receiving, and we rejoice that one of our Society members is so signally honored.

THE KENNEY FOUNDATION DRIVE

The recent series of articles in the *Providence Journal-Bulletin* on the question of need for a national voluntary health fund, with particular study of the activity of the National Foundation for Infantile Paralysis, had hardly been reprinted when we were faced with the news announcement of the planned campaign of the Kenny Foundation. Undoubtedly confusion will exist in the mind of the public, as it did in ours, when this second drive for funds for aid to polio sufferers is launched.

In an effort to secure some clarification of the problem we have sought information from the National Foundation for Infantile Paralysis. Their answer is reprinted below. We agree with the statement that "this is a free country, and anybody has a

right to run a drive for any cause", but we think it is high time that the public be fully informed of all details regarding any existing or proposed campaign for funds that are sought for health interests, and that duplication of efforts be minimized for the advantage of the giver, as well as for the protection of the receiver.

The answer to our inquiry to the National Foundation for Infantile Paralysis is as follows:

"The National Foundation for Infantile Paralysis does not establish standards for medical care or treatment of infantile paralysis. Each state has its own laws regulating the practice of medicine. The National Foudation assumes that these laws are acceptable to the people of the states who made them. Such laws, therefore, are acceptable to and will be followed by the National Foundation.

It is our policy to pay for the medical care of infantile paralysis only in those cases treated by physicians who are duly licensed to practice medicine and surgery in the states where the treatment is rendered. We make no effort to interfere in the patient-physician relationship. The type of treatment prescribed is entirely up to the doctor.

In view of the foregoing, you can see that as an organization we have no viewpoint toward the Sister Kenney treatment, other than to recognize that it is being given in a great many hospitals throughout the country, and necessary equipment and personnel for giving it, when prescribed by physicians, is paid for by National Foundation Chapters. In Minneapolis this summer the Chapter already has paid more than $30,000 to the Kenny Institute for the care of infantile paralysis patients whose families could not meet these expenses without assistance.

We have advanced from the New York headquarters to the Polio Emergency Committee in Minneapolis a total of $240,000 thus far. To the whole State of Minnesota we have sent $551,555.

In regard to your question about how we view the Kenny Foundation drive schedules for November, I can only say that we have no connection with it. This being a free country, anybody has the right to run a drive for any cause.

I suppose you have been somewhat confused by the statements attributed to other than the National Foundation stating that the medical profession and the National Foundation are "against" the Kenny treatment. This statement has no basis in fact. The vast majority of patients whose medical and hospital bills have been paid by our Chapters are receiving hot packs and physical therapy, which are the essence of the modern treatment of infantile paralysis. Miss Kenny, whose first work in this country was financed by grants from the National Foundation to the University of Minnesota, has played an important role in popularizing this kind of treatment. It is estimated that at least 85 per cent of the physicians treating infantile paralysis today use the modern method."

PROGRAM ON THE CARE OF THE HEART

Interest in the control of heart disease is currently being enhanced by the efforts of many professional and lay groups. This attention to heart ailments has long been warranted. The public is becoming more acutely aware of cardiac hygiene than ever before — a growing interest that should be cultivated and guided with judgment as well as vigor.

During the past third of a century, the improvement in mortality from heart disease was most pronounced in the younger age groups and decreased progressively with advance in age. The death rate from diseases of the heart and arteries, corrected for the ageing of the population, dropped virtually 30 percent between 1911-15 and 1940-44, according to experience among the Industrial policyholders of the Metropolitan Life Insurance Company. This reduction in mortality from the principal cardiovascular-renal diseases has been particularly marked among white females — 37 percent in the above-mentioned period. Among the males, the decrease in mortality, while not as marked as among the females, was 25 percent, still a quite substantial reduction. This still leaves much to be desired in the field of early diagnosis and immediate initiation of adequate cardiac regimes in order to reduce to a minimum incapacity and mortality from these conditions. Concentration of effort must now be placed on teaching the public what is known about prevention, early recognition, and care of cardiac lesions.

In order to assist in the attainment of this goal, the Metropolitan Life Insurance Company is conducting a special campaign on heart disease during the fall and winter months. At that time, the Company's more than 20,000 Field Representatives, in cooperation with official and voluntary agencies, will reach the homes of millions of policyholders with a recently published pamphlet, YOUR HEART, developed in cooperation with the American Heart Association. A lay educational film on heart disease is also being prepared. Distribution will be made to physicians of a packet in which will be included material of special interest to doctors, and a scientific exhibit on heart disease, first shown at the A.M.A. meeting in San Francisco, is available for State and local professional meetings.

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PROLONGED ENDOTRACHEAL OXYGEN

A Case Report

ORLAND F. SMITH, M.D. *and* LT. COMDR. ROBERT E. DOUGLAS, MC, USN

The Author, *Orland F. Smith, M.D., of Pawtucket, R. I., Transfusionist and Junior Assistant Surgeon, Memorial Hospital, and Assistant Surgeon, Out-Patient Department, Rhode Island Hospital. Lt. Comdr. Robert E. Douglas, MC, U. S. Navy, of Somerville, Massachusetts.*

THE combination of circumstances that will occasionally arise to harass the surgeon constitutes a favorite topic of conversation at all surgical gatherings, large and small. The unusual case is the one that frequently teaches us most, and unquestionably serves to help both surgeon and patient when a situation that is even remotely similar is again presented.

Spinal anesthesia during the past decade has become the anesthetic of choice in abdominal surgery in many clinics and hospitals. The degree of perfection which the anesthesiologist has attained in managing his patient has undoubtedly helped to create a more careful and methodical type of surgeon, with the obvious survival of many patients who, a few years ago, were doomed to become operating room casualties. The era of watching the clock has long since passed, and the individual at the head of the table is assuming the place he has so rightfully deserved for so many years. There is little question in my mind that the progress in anesthesia of all types during recent years represents one of the greatest single advances we have made in general surgery. This is not a new thought, but has not been expressed sufficiently often in surgical literature and in the classroom to emphasize adequately the need for that meticulous attention to detail which the pioneers in the field of anesthesiology have struggled so long to establish. The following case report will demonstrate some of those details.

R.H.O. Case No. 9064.

A well developed and well nourished 19 year old male entered the hospital complaining of abdominal pain following the discharge of a rifle bullet into his upper abdomen one hour before admission. His history otherwise was essentially not remarkable.

On admission to the hospital the physical examination showed an extremely drowsy patient, who could be easily roused. His skin was pale and his pupils were contracted. The history accompanying him stated that he had been given 16 mg. of morphine sulphate subcutaneously, forty-five minutes prior to entry. His abdomen was exquisitely tender and rigid throughout. The bullet entrance wound, one half inch in diameter, exuding dark blood, was observed in the upper left quadrant, just above the umbilicus, and lateral to the linea semilunaris. The exit wound was larger and more ragged, two inches from the midline of the spine on the left, at the level of the iliac crest. His pulse was steady at 100, and blood pressure 126/80. His physical examination was otherwise essentially normal. A flat plate of his abdomen was reported negative for demonstrable soft tissue pathology and pneumoperitoneum.

He was immediately taken to the operating room and prepared for abdominal exploration. At 12.45 P.M. he was given another 16 mgm. morphine sulphate sub-cutaneously, with 0.4 mgm. atropine sulphate. At 1.55 P.M. he was given 20 mgms. pontocaine plus 2.5 cc. 10% dextrose solution between L4 and L5, through an hematoma in the tissues surrounding the wound of exit. The rate of injection was 1 mg. per second for twenty seconds with the patient in ten degrees Trendelenberg position. One-half cc. neo-synephrin was given intramuscularly. The table was levelled in 65 seconds, and at the end of two minutes the anesthetic had reached T3. A previously prepared plasma transfusion was started via the right ankle. Projectile vomiting of a large amount of coffee ground material occurred at 2.03 P.M., followed by immediate cessation of respirations. Blood pressure zero, pulse not obtainable, and cardiac sounds not audible. Artificial respirations were started immediately via face mask. The skin was moist, cold, but pink about the lips. All reflexes including corneal were absent, and cardiac sounds were inaudible. Vomitus was aspirated through an oral airway which was inserted at 2.07 P.M. At 2.12 P.M. a McGill intratrachael tube was inserted and converted to the C0 2 absorption filter with 100% Oxygen, using the bag as a closed respirator at 17 respirations per minute. The plasma was continued, and during the following fifteen minutes he was given 13 cc. of intravenous Coramine. Both bronchi were aspirated of a small

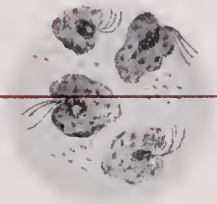
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pH 3.8 to 4.4

NORMAL PROTECTIVE DÖDERLEIN BACILLUS

at what pH

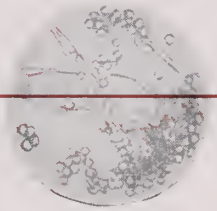


pH 5 to 6

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pH 5.5 to 6.8

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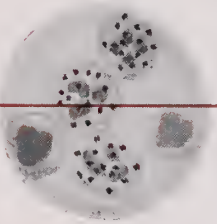


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RESEARCH IN THE SERVICE OF MEDICINE

PROLONGED ENDOTRACHEAL OXYGEN

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amount of blood tinged watery fluid. The lips continued to remain pink. Fifty minutes after closed respirations were started a corneal reflex was obtained. At 3.10 P.M. he gave his first spontantous abdominal gasp, and commenced rhythmic respirations five minutes later. The intra-trachael tube was removed at 3.20 P.M., and ½ cc. of neo-synephrin given intra muscularly. His pulse was palpable for the first time immediately after his first voluntary respiration. Heaters were applied, and the patient was quite comfortable until 4.30 P.M., at which time he again began to complain of abdominal pain. Another 16 mgm. of morphine sulphate was given. At 4.45 P.M., he still had slight skin anesthesia to T6. At this time the spinal anesthetic was repeated, using 150 mgm. procaine via T4-T5. He was then held in 10 degrees Trendelenberg for two minutes, with no greater height of anesthesia than the T6 level. Five hundred cc. of whole blood and 250 cc. of plasma were started at this time.

A left rectus muscle splitting incision was made at 4.55 P.M. entering the peritoneal cavity without difficulty. The latter was filled with blood. Two perforations in the stomach, one-half inch from the greater curvature were closed with two layers of 00 chromic catgut in each, and reinforced with interrupted silk. The small bowel was examined and two perforations were found ten and twelve inches from the Ligament of Treitz. These were closed in in a similar manner as the stomach. The entire small bowel and large intestine were examined and no additional pathology could be found. A small tear in the mesentery was found a foot below the lower wound, and had missed the bowel at this point by one-half inch. The wound of exit was seen at the base of the mesentery, on the lateral border of the psoas muscle. The liver, spleen and kidneys were palpated and no abnormality found. Likewise there was no apparent damage to the bladder or ureter. 100,000 units of penicillin and five grams of sulfanilimide were placed in the peritoneal cavity and the peritoneum closed tight. A rubber tissue drain was placed to the peritoneum after excising the muscle damaged by the bullet. The skin was closed with interrupted black silk. During the elapsed time in the operating room he was given 1000 cc. plasma, 500 cc. whole blood, and 13 cc. intravenous coramine.

He was returned to the ward, placed in an oxygen tent at six litres, and a Levine tube on Wangensteen suction inserted intranasally into the stomach. During the following twenty-four hours he was given 30,000 units of penicillin every three hours, 5 grams of sodium sulfadiazine in 1000 cc. of normal saline, 1000 cc. 5% dextrose in water, and 1000 cc. 5% amigen in 5% glucose intravenously. Oxygen was discontinued at the end of twenty-four hours. His gastric drainage during the first 36 hours was 2040 cc. At the end of 36 hours the Levine tube was clamped off on alternate hours, and he was given one-half ounce of water by mouth every half hour. The suction drainage amounted to 1410 cc. during the next twenty-four hours. The penicillin, sulfadiazine, and intravenous fluids were discontinued after forty-eight hours. His fluid intake by mouth was increased to 1 ounce of water every half hour on his third day. His urinary output was 1805 cc. during the first thirty-six hours, and remained above 1200 cc. daily thereafter. On the fourth day the drain was removed from the wound, and water by mouth increased to two ounces. On the fifth day he was given a glycerine and water enema with a good flatus and fecal result. A 5th day Balfour diet was started and well tolerated. The Levine tube was removed on the third day, and inserted at twelve hour intervals for measurement of the gastric residue. This was repeated only twice, as the residue amounted to less than 20 cc. each time. On his seventh day he had a normal bowel movement. The total dosage of penicillin was two million units. The sutures were removed on the seventh day, and he was allowed out of bed. On his ninth post-operative day he was on a full house diet.

A G.I. Series on his fifteenth day disclosed a temporary dilation of the third portion of the duodenum, which emptied rapidly thereafter. No definite obstruction could be found in the 1st portion of the jegunum. The stomach was empty at the end of five hours, and the motility of the small bowel was normal. The remainder of his convalescence was uneventful, and he was returned to the U. S. A. at the end of one month for further rest.

Comment

The course taken by this patient after such a desperate situation is unquestionably unusual. To run an uncomplicated course was naturally most gratifying to all concerned, and at the same time entirely unexpected. The reaction following the introduction of the spinal anesthetic was undoubtably due to the latter, although the symptoms were not entirely classical. In view of the complete recovery after such a long time with no evidence of life, it is not reasonable to assume that so many physiological fundamentals could be so flagrantly violated without having many questions arise. The decision to use spinal for the second time in this patient admittedly needed courage, but we had nothing better. The case is presented solely for its clinical interest, as well as to demonstrate the value of prolonged effort in resuscitation.

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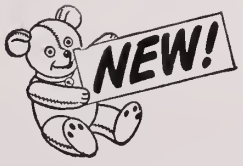
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Shambaugh, G. E., Jr. J. Iowa M. Soc. 31:375.

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continued from page 756

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Physicians are urged to comply with the Federal narcotic law by writing all naroitic prescriptions with ink or indelible pencil and not to request or expect the druggists to violate the above regulation.

Further, physicians are reminded that it is a violation of the Federal narcotic law for a druggist to refill a narcotic prescription. If a druggist fills an order for narcotics reading "Refill Rx No. ....." he is refilling a narcotic prescription and would be in violation of the law.

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THE IMPORTANCE OF THE X-RAY DEPARTMENT

EMANUEL W. BENJAMIN, M.D.
Radiologist, The Memorial Hospital, Pawtucket

IN November 1945, the world at large celebrated the 50th anniversary of the discovery of the roentgen ray. This span of years is short enough so that a great number of people alive today have seen the continuous and vast progress which this discovery initiated. Year by year, and with increasing speed, improvements and advances along technical, therapeutic and diagnostic lines have taken place. This specialty has annually contributed more and more to the diagnosis, treatment and prevention of disease, so that at the present time the x-ray department constitutes an integral and indispensable part of the physicians armenentarium in the endless warfare against disease. This is particularly so in hospitals.

About seven years ago, the trustees at the Memorial Hospital, after long study, decided on the erection, operation and maintenance of a *new* x-ray department which was a direct recognition of the importance that this specialty had come to play in medicine. Accordingly, and with great foresight, an x-ray department was laid out without any encumbrances due to previous installations, and adequate consideration was given for future expansion. The most modern equipment and installations were provided and these have been replaced in recent years as new and better equipment was made available. In addition, the trustees very wisely saw fit, on recommendation, to allot a large floor space for a demonstration room. This demonstration room is a relatively new thought for an x-ray department and has in the past been held to be more or less of a waste of valuable space, and a needless and expensive appendage. However, during the years this room has come to be a focal point of interest in the hospital and has fully compensated for any effort entailed. It provides comfortable seating capacity for thirty-five to forty people, and is a meeting place for physicians of the various services where they obtain a clearer understanding regarding the diagnostic problems involved in x-ray, with the ultimate, perhaps intangible benefit to the patient. Furthermore, in the early years of the tumor clinic, this room served as a meeting place for this new service.

The department, as stated, was planned with a view to the future, particularly in anticipation of the establishment of the tumor clinic. This clinic is a particularly noteworthy effort in the public service for the diagnosis and treatment of cancer, particularly since the x-ray department plays such an important role in this field.

The department comprises a floor space of 3,758 square feet and is composed of two diagnostic rooms, one of which is equipped for fluoroscopy, a cystoscopic x-ray and operating room, and a deep x-ray therapy room. The radium room, originally a part of this department, was moved elsewhere to make facilities more conveniently available to the main operating corridor. In addition, there is a large waiting room, record room, doctor's disrobing room, dark room, as well as a small office for the radiologist and adequate facilities for storage of films and other records. Several other rooms, including the radiologist's office and a small accessory waiting room, are incorporated in the department, which, if necessary, can be later converted to provide another x-ray room.

The department during the past seven years has been able to absorb the marked increase in the demands put upon it by the general services and private wards, as well as the active tumor clinic. During this period of time, the work in the x-ray department has more than doubled and this year alone an additional twenty-five percent increase has been experienced.

These remarks have been set down to indicate the importance of the x-ray department in a general hospital, and to stress the value of a far-sighted policy as shown by the progressive attitude of the trustees who, incidentally, permitted the department to be laid out from the standpoint of the radiologist and other physicians of the staff, resulting in an efficient x-ray service for the patient.



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EXPERIENCES WITH SYMPATHECTOMY

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glion. All connecting branches to the sympathetic trunk, from the intercostal nerves, second and third, are severed, and the intercostal nerve itself is cut across just proximal to the dorsal root ganglion. The second intercostal nerve is treated in like manner. This procedure produces a preganglionic type of denervation of the upper extremity on the side performed, and if properly done gives a very splendid enervation of that extremity almost equal to the satisfactory results produced by lumbar sympathectomy. There is, however, a greater tendency of recurrence in this region, and in some instances, the sympathetic trunk is encased in a silk cylinder especially when an intraspinal section cannot be performed.

Experience: To date eighty-six surgical procedures have been performed upon fifty-seven patients. Forty-nine lumbar sympathectomies have been done on thirty-six patients with no mortality. Thirty-one thoracolumbar sympathectomies and splanchnicectomies have been performed on seventeen patients with one death. This patient died twenty days postoperative of cerebral thrombosis. Six thoracic sympathectomies have been performed upon four patients with no mortality. A detailed analysis of cases with follow-up will be reported in the near future.

Summary

1. Sympathectomy is defined. A brief review of its historical background, anatomy, and physiology is given.[1]

2. Lumbar sympathectomy is indicated in Buerger's disease, many cases of Raynaud's disease, impaired arterial circulation of lower extremities in presence of vasospasm, excessive hyperhydrosis of nervous origin and certain cases of chronic ulceration.

3. The surgical technique of lumbar sympathectomy is given.

4. High blood pressure and its treatment by sympathectomy is discussed.

5. The technique of sympathectomy for hypertension is described.

6. The technique of thoracic sympathectomy for denervation of the upper extremities is given.

7. Eighty-six surgical operations on fifty-seven cases are reported.*

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**Figures corrected to August 16, 1946.*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held at 8:45 p.m. September 19, 1946, at the To Kalon Club, Pawtucket. The program was arranged by Dr. Charles L. Farrell.

The meeting was called to order by the President, Dr. William N. Kalcounos. A motion by Dr. Edward Foster to dispense with the reading of the minutes of the previous meeting was seconded and passed.

Applications for membership in the Pawtucket Medical Association were received from Dr. Bert Simmons Jeremiah and Dr. Henry Edward Turner. They were referred to the Standing Committee.

Dr. Orland Smith rose to request a few minutes to discuss medical education. He noted that the trend seemed the same as followed World War I, with Specialty Boards being emphasized and General Practice being relegated to the background. He said that in a recent discussion by a group of Pawtucket doctors the general opinion was to present to the Medical Association their views. Therefore, he introduced a motion that a committee be appointed by the President of the Pawtucket Medical Association to meet a committee representing the executive committee of the staff of the Memorial Hospital to discuss the following three questions:

1. Is it necessary for the head of a department to be a diplomate?
2. What is the fate of the non-diplomate?
3. What is the attitude of the hospital authorities about qualifications for regular promotion?

The motion was seconded by Dr. Charles Farrell and unanimously passed.

The meeting was then turned over to Dr. Charles L. Farrell who introduced the Speaker of the evening, Dr. H. Lorenzo Emidy, Chief of Pediatrics at Woonsocket Hospital and a member of the American Academy of Pediatrics. Dr. Emidy's topic was Infantile Paralysis — Early Diagnosis and Treatment. His remarks were informal and supplemented by films taken at Chapin Hospital. The final round-table discussion considered the Kenny treatment, late summer tonsillectomies and the present outbreak in Woonsocket which Dr. Emidy declared was not an epidemic and would not be one.

Following a buffet supper the meeting was adjourned.

The following regular members were present: Drs. Barry, Beaudoin, Boucher, Gaudet, Gordon, F. Hanley, Foster, Farrell, Healey, Hecker, Hennessey, McCaughey, Tetreault, Wheaton, Sullivan, Henry, Woodcombe, and Zolmian.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D., *Secretary*

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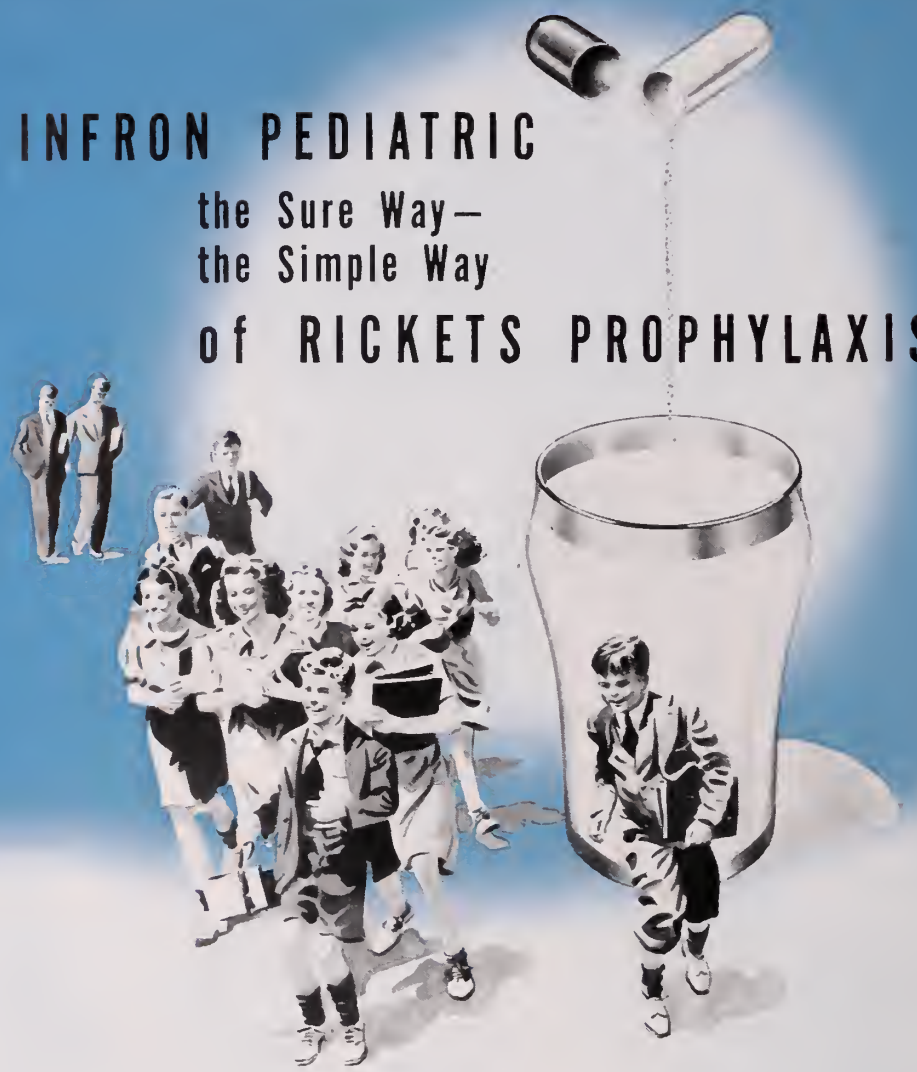
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PUBLIC HEALTH IN RHODE ISLAND

Abstracted from A Study of State and Local Relationships, *prepared and published by the Rhode Island Public Expenditure Council, September, 1946.*

The first proposal on record in Rhode Island for the levying of a tax was in 1640 when it was desired "to erect a fence five rails high at the head of the spring" in Portsmouth. Although it is said the tax was never assessed and the fence was not built, the incident nevertheless discloses an early recognition of a need for local sanitation as a prevention against pollution of the water supply. From this small beginning there has developed over the years a wide variety of public services which commonly, but not too accurately, are classified as public health functions, and which cost the taxpayers in excess of $2,500,000 annually.

Responsibility of organized society in matters of public health rests primarily on the well established principle that no person may use his property or conduct himself in a way to injure any other person. An individual taken by disease which is communicable may, through indifference or ignorance, transmit that disease to a large number of other persons; or he may maintain sanitary conditions that are a menace, not only to his own health, but to the health of the community. Government, therefore, assumes the right to regulate the conduct of citizens in such a way that their acts or delinquencies do not work material injury to others. It may not, under ordinary circumstances, compel the individual to provide for his own health betterment, or that of his family, as long as he does not criminally neglect the welfare of his dependents, but nevertheless government has undertaken to provide health education and instruction of the individual and health aid to those who need them. In the past, health aid for the most part has been limited to those who otherwise would be incapable of obtaining it, but recently such a limitation has been more or less disregarded.

Health Functions Classified

The basic health functions, usually performed by most governments—local, county, or state—may be grouped into six major classifications as follows:

(1) Vital Statistics — recording births, deaths, marriages; and research.

(2) Prevention and Control of Diseases — registration, investigation, control.

(3) Protection and Promotion of Child Hygiene — education, assistance, expectant mothers, infants, midwives, maternity hospitals, school age children, working papers, etc.

(4) Public Sanitation — environmental health hazards, food, milk, drugs, water supply, sewerage, working conditions, etc.

(5) Supervision of Persons and Institutions Concerned in Healing Arts — licensing physicians, dentists, osteopaths, etc., hospitals, pharmacies, etc.

(6) Public Health Education.

Public health services are provided by the Federal government, the state government, the local governments, and many private agencies. In Rhode Island the work of certain private agencies such as the District Nursing Associations and some of the hospitals, occupies a field of activity which elsewhere is more commonly supported exclusively by public financing.

Today in Rhode Island there is probably more uncertainty in the respective responsibilities of the state and local governments for the performance of the many activities falling within the broad category of public health service than in any other major function of government. The General Assembly in effect admitted as much when, in authorizing a special commission in 1943 to study the entire question of public health service, it stated, "It is evident that there is no clear-cut division of responsibility, with some services being performed by the state and others left to the varying cities and towns, resulting in confusion as to final responsibility for the efficient performance of public health functions."

Common Pattern Lacking

As is the case with all public service, full responsibility in theory rests exclusively with the state, except for those food and drug activities, which have been taken over by the Federal government under the interstate commerce clause. Actual administration of certain services has been left largely with the local governments though there is no common pattern for the provision of these services except for the recording of vital statistics. For example, in Providence and one or two other communities, an extensive public health program is provided, while in many other communities practically all health service is provided by the state. It is a fair generalization to say that any community which

continued on next page

deliberately neglects its health responsibilities may be reasonably certain the state will step in and provide at least minimum service at no cost to the local government. Though it is fortunate that the state accepts this responsibility, it results in an unfair tax burden on those communities which discharge their obligations and meet their own proper charges.

There is another angle to this problem, however, which merits consideration. Many of the small local governments have neither the financial resources nor the personnel to provide proper health service. And even though the financial resources may be adequate, the cost of providing a proper health program for a small population would be uneconomical. Modern public health service requires a variety of especially trained skills, and very few of the state's thirty-nine cities and towns would be warranted in attempting to employ an adequate personnel exclusively for their own needs.

Before attempting to rationalize this situation, it is appropriate to review briefly the public health functions as they are now organized and administered.

Vital Statistics — Records of vital statistics are reported to the local governments which in turn report them to the state. Public health law declares that the town clerks of the several towns or "any person whom the board of aldermen of any city or the town council of any town may appoint for that purpose" are responsible for recording correctly and transmitting each month to the state Director of Health the originals of certificates of births, marriages, and deaths registered by them, and for maintaining complete and accurate copies thereof in their own offices. The state Director is ex officio state registrar of vital statistics since it is necessary to comply with conditions imposed upon the states by the United States Bureau of the Census in order that the state of Rhode Island may be included in the "registration area for births and deaths" and its statistics accepted as comparable with those of other states comprising the registration area.

Doctors, clergymen, undertakers, and others required by law to report births, deaths, and marriages are paid small fees, generally twenty-five cents for each case reported. These payments are required by state law, but the amounts so paid are a charge against the local treasuries.

The compensation of registrars in many local governments consists of small fees ranging from twenty to fifty cents for registration of birth, death and marriage certificates, issuance of burial permits and certified copies of vital records. These fees for the most part are paid by the local governments except in the case of certified or uncertified copies of vital records, which are paid for by the applicants.

Comments: Although the state Director of Health is state registrar of vital statistics, his responsibility is in part shared with locally appointed officials who receive the original information.

To be useful, it is essential that vital statistics be recorded accurately and for this, adequate medical knowledge is highly desirable. Although responsibility for reporting the specific and contributing causes of disease is placed on the reporting physician, errors and inaccuracies are encountered, and the recording official should be sufficiently skilled to detect such mistakes at their inception. It is unlikely that town clerks and clerical registrars will possess this knowledge. Moreover, it is doubtful if officials who receive only small fees as their compensation will be of the type that will insure valid records.

Full research and interpretation are not now being done on vital statistics records.

Control of Diseases — The public health law declares that the state Department of Health "shall take cognizance of the interests of life and health among the citizens of the state; shall make investigations into the causes of disease, the prevalence of epidemics and endemics among the people, the sources of mortality, the effect of localities, employment and other conditions and circumstances on the public health, and do all in its power to ascertain the causes and the best means for the prevention of disease of every kind in the state." To perform this function the state maintains a Division of Communicable Diseases; a Division of Services for Crippled Children; a Division of Laboratories; a sanitorium at Wallum Lake and other services for the tubercular; a special program for the control of cancer; supervision over conditions affecting the health of industrial and other workers; and a variety of other activities relating generally to the control and suppression of disease. An important aid to the performance of a major part of this function is the requirement that physicians and other persons (superintendents of hospitals, etc.) having knowledge of any infectious or contagious disease shall report their cases to the state Department of Health.

Health Is State Responsibility

Although it is difficult because of the innumerable individual laws relating to public health to be certain of any summarization, it seems clear that responsibility for the control of disease rests primarily on the state. Local health officers have certain duties to perform, but these duties are largely routine in character and could be performed by any lay person. Moreover, it is not apparent that local health officers have any specific sanction in the law to move on their own initiative to prevent or suppress either contagious or noncontа-

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PUBLIC HEALTH IN R. I.
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gious diseases. Cities and towns which provide such services apparently do so under authority of special acts, or by arrangement with the state Director of Health who has broad authority to delegate his powers to subordinates and agents. For the state as a whole, however, it is clear that responsibility for the control of disease rests with the state authorities.

Local boards of health and local health officers are authorized by law primarily for the regulation and control of local nuisances, but these officials, when they possess proper qualifications, could be in an effective position to perform a valuable service in the control and prevention of diseases since their work is at the local level. Furthermore, as their appointment must be approved by the state Director of Health, effective cooperation should be assured. As a matter of fact, however, there are evidences that the contact between the state and local officials is not particularly satisfactory. Some local health officials resent any state "interference."

The inadequacies of local health service in certain communities have prompted the state to establish four district health units, chiefly for the areas outside of Providence which do not or cannot provide an adequate service for themselves. In general, this has produced fairly satisfactory results though it again raises the question of equitability as between the local governments in the matter of meeting the cost.

Comments: The wide differences in mortality rates of certain communities of more or less similar characteristics indicate a need for more thorough and uniform performance.

Existing laws are uncertain and indefinite in establishing duties and responsibilities.

Too many local health officials have neither the qualifications nor the interest required for modern health programs.

Protection and Promotion of Child Hygiene — Child health supervision is the most hopelessly divided function of any of the major public health services. The law (Section 17, Chapter 255) declares that "There shall be in the department of public health a child welfare bureau under the charge of a physician for the study and application of measures for the prevention of maternal and infant mortality; for the preparation and issuance of child health literature, the suppression of diseases of young children, and the organizing of child hygiene work, and for the institution of such other measures for the protection of the lives and the improvement of the health of young children as the said department and bureau may deem necessary."

No Central Authority

Authority over the entire range of child health is not now centered in the maternal and child health division, but is dispersed among several state departments — Labor, Education, and Welfare; the Division of Services for Crippled Children; the health organizations of thirty-nine local governments; the school committees in the thirty-nine local governments; and a score or more of unofficial health organizations scattered throughout the state in local communities. In addition, the Federal government through various subsidies for specific purposes exercises a significant control. In infancy and during the pre-school age, the state's effectiveness in promoting better child health is limited by dependence upon the efforts of private nursing associations which receive from the local governments grants for their official cooperation. In the school years child health programs are administered generally by the local school committees under the supervision of the state Department of Education. The administration of other phases of child life including child labor and child health safety rests with the Department of Labor. In short, the supervision of child health from the beginning of life to its legal termination is so divided among the state and local governments and private agencies, that no single agency has complete responsibility for a well conceived, well directed program for the entire range of child health.

Four or five child health nurses are assigned to each of the four district health offices to cooperate with local officials and unofficial agencies engaged in child health work. This program is carried on throughout the state with the exception of Providence, Pawtucket, and a few other cities and towns in the southern section of the state, where the function is performed at local expense. Diphtheria immunization is carried on in most cities and towns, and immunization and testing programs for whooping cough and tuberculosis are also provided. A dental program is provided in communities which do not otherwise provide the service locally.

Comments: In general the state Department of Health is attempting to provide maternal and child health service in those areas which either do not or cannot provide adequate service for themselves. The organization is faulty and relies heavily on unofficial assistance. Local health authorities have little or no responsibility for promoting these services, except such as may be assumed by local initiative. In the matter of servicing children of school age, the relationship with local school authorities is entirely informal, and responsibility for promoting health service in the schools rests largely on the state Director of Education.

Existing child health laws are indefinite and unsatisfactory. The state assumes the greater share

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1. *Lennox, W. G. (1945), Petit Mal Epilepsies: Their Treatment with Tridione, J. Amer. Med. Assn., 129:1069, December 15.*
2. *DeJong, R. N. (1946), Effect of Tridione in the Control of Psychomotor Attacks, J. Amer. Med. Assn., 130:565, March 2.*

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of the responsibility, but in the actual performance of the services, it necessarily must rely on information, personnel and conditions which are essentially local in character.

On the other hand, a substantial portion of the actual work involved — inspections, inoculations, advice — requires both skilled and semi-skilled personnel. In many communities adequately trained personnel is not available.

Service with school children now tends heavily toward disease prevention and curative or remedial efforts, and it is quite likely that the school committees require professional guidance in such matters. Where education leaves off and health service begins gives rise to a difficult problem of organization relationships.

Public Sanitation — Public sanitation embraces a wide variety of health services necessary to the prevention and elimination of all environmental health hazards named in the laws as menacing to health, and also all necessary controls of foods and food products, milk and milk products, water supplies and other beverages, and methods and practices in all places dealing with these commodities or utilities. Within this broad classification is included a considerable number of variously organized services such as the prevention of pollution of public and private water supplies; the enforcement of laws dealing with the handling of milk; the inspection and regulation of aquatic recreational facilities; the administration and enforcement of the state pharmacy laws; the control of sewage; inspection and regulation of shellfish waters and the shellfish industries; control and inspection of public eating places; prevention of local nuisances; regulation of slaughter houses; etc.

Overlapping Services Noted

For the most part, these services are performed by the state Department of Health, though control of milk and diseases of cattle which in turn affect the milk supply, are primarily the responsibility of the Department of Agriculture and Conservation. Control of narcotic drugs in part overlaps the responsibilities of the Federal government, and in certain food controls the activities of the state meet but do not overlap the services of the Federal government. Local nuisances are left largely to the local governments and though there are conditions in some of the local units that should receive attention, efforts on the part of the state inspectors to make inquiries or studies without invitation from the local authorities often are resented. Many of the local governments attempt to maintain milk inspection, though it is the opinion of several local health officers that much of this service is unsatisfactory due largely

continued on next page

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PUBLIC HEALTH IN R. I.

continued from preceding page

to the lack of proper training of the local inspectors and to inadequate facilities. The state Department of Health takes samples and makes inspections of milk and to a considerable extent duplicates the work of the local inspectors and of the agriculture department.

In matters of water pollution, sewage and shellfisheries, the state exercises practically all control. In matters of local sanitation which include not only nuisances but control of public eating places, drinking establishments, hotels, camps, etc., the general policy seems to be that the state leaves this work to the local governments except when complaints are received or when the local governments neglect or refuse to perform their functions properly. Such a policy is sanctioned by law, for Chapter 714, P. L. 1939, after providing that the Director of Health shall enforce the sanitary laws, adds the provision "that authority for such enforcement may be delegated to the board of health of any city or town at the discretion of said director of health." There is prevalent on the part of the state authorities a disposition to refrain from "interfering" with the local governments, and there is evident on the part of too many local officials a disrespect for the state officials. This condition is not conducive to good health work and as a result the people as a whole suffer.

Comments: A considerable portion of public sanitation service is performed by persons unqualified by experience or training for the job. In a few services such as sanitary engineering wherein the state has set fairly high personnel standards, the work is being done in a superior manner. In most other instances at both the state and local levels the importance of proper training and experience does not appear to be widely recognized and the results appear to be unsatisfactory.

Laws governing these activities for the most part have been enacted piecemeal, and there are many uncertainties in authority and responsibilities.

Laws concerning milk are definite and local milk inspection as at present performed is largely a waste of effort and money.

Control over eating establishments is divided and neither the state nor the local governments are performing an adequate service.

Supervision of Persons and Institutions Concerned in Healing Arts — The one function which the state has assigned completely to itself is the licensing, supervision and regulation of physicians, dentists, osteopaths, optometrists, chiropractors and other practitioners in the healing arts. Likewise it licenses and supervises pharmacists, nurses,

continued on page 778

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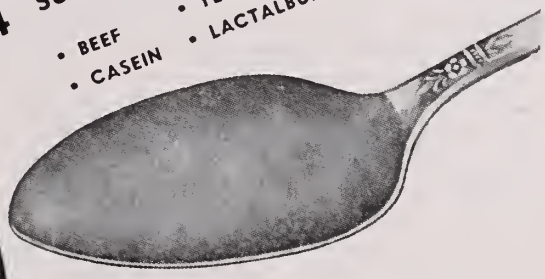
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Literature on Request

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continued from page 776

embalmers, barbers, hairdressers, veterinarians (in the Department of Agriculture), sanitary engineers, plumbers, etc. Most of these licensing functions have been assumed as a means of providing a control over the persons directly concerned in health services. By requiring licenses which are always revokable, reporting of cases and information can be compelled, minimum standards can be maintained, and health work generally can be policed. It is primarily the latter function of "policing" which justifies the state health department in performing the licensing function. Without it the department would have little control over the tools or instrumentalities through which it must work. Although some authorities suggest that the function of granting an original license should rest with the Department of Education since it is largely a matter of measuring training, education and experience, the important service insofar as the public is concerned is that of insuring proper performance, and if the Department of Health is to be held responsible, its authority over licenses should be complete and undivided.

Comments: Licensing power is essentially a policing authority, and it is primarily in the furtherance of that power that the state has a legitimate concern. Laws establishing examining boards generally provide a membership exclusively from within the profession concerned. For strictly examining purposes this is perhaps necessary, but by creating these boards more or less as independent units, the importance of the broad public interests tends to be minimized. It would seem appropriate that provision be made either for a general board to supervise the work of the special examiners or for some representative of the public interest on the specialized examining boards.

Public Health Education—Information for both professional and public use on approved methods of combating disease, warnings and counsel on epidemic conditions, and the constant dissemination of public health advice are commonly regarded as essential health functions. State laws definitely place responsibility for this service on the state Department of Health and local governments have authority to request of the state department such advice as they may require.

In actual practice both the state and the local governments provide certain educational services though there is little evidence of any continuing program of a broad general character. All authorities emphasize the value of the widest possible dissemination of health information, and judged by such standards, Rhode Island suffers by comparison.

Comments: So little is being done to promote public health information, comment necessarily is limited.

Theoretically, the state should be responsible for the analysis of health conditions and for the preparation of educational material. The disseminating of such material can be done by either the state or local governments.

Summary and Suggestion

Although it runs the risk of oversimplifying a complex series of relationships between the state and local governments in the field of public health administration, the following summarization of existing conditions appears to be justified by law, expenditures, and actual operations.

Vital Statistics —
Predominantly local. State's part is essentially routine. State should do more on research and interpretation.

Control of Diseases —
Predominantly local. Service is rendered at local level even when state provides the service.

Child Hygiene —
Divided — Federal, state, local, schools. Service actually is rendered primarily at the local level.

Public sanitation —
Divided — Pollution and problems requiring engineering by state; local nuisances locally controlled; eating places, etc., both state and local.

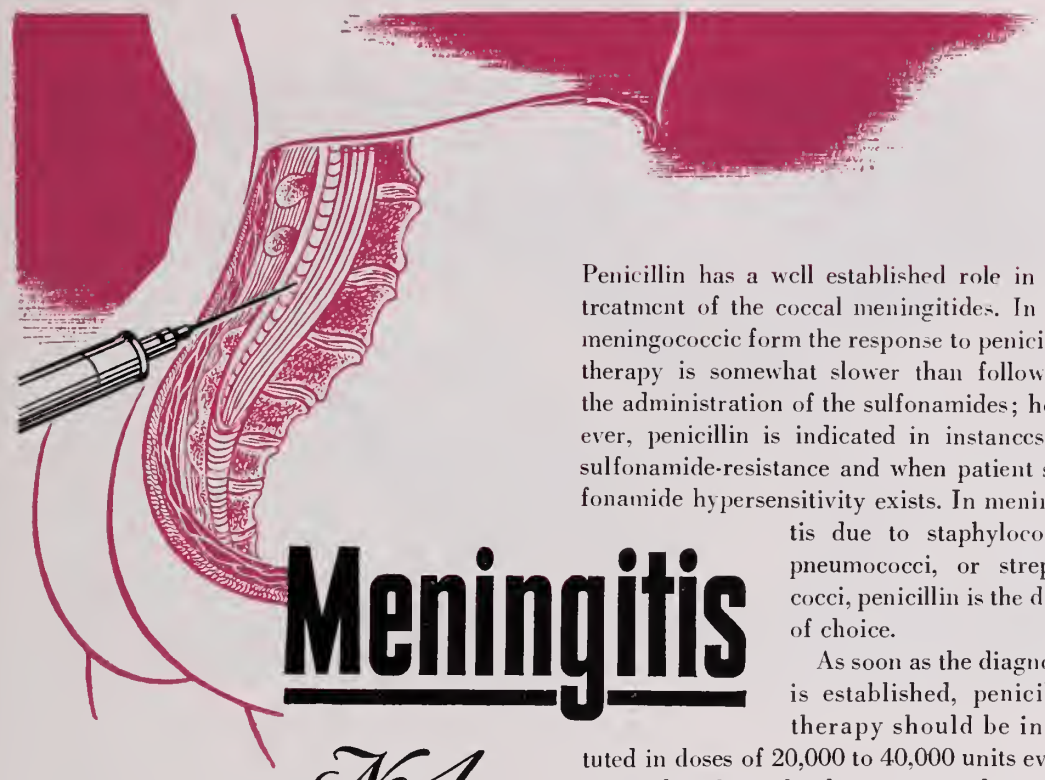
Supervision of Health Sciences and Trades —
Entirely state.

Public Education —
Divided.

Traditionally public health service has been operated as a local service for it deals largely with people, institutions and conditions. Regardless of how it is organized and financed, it necessarily must be rendered at the level or within the environment at which these subjects exist. The state itself recognizes this necessity when it operates certain of its services through local district offices.

Expansion of state public health services appears to have come about largely as a result of inadequate local service. This in turn probably is the result of inadequate local understanding of the importance of public health measures, limited local financial resources, and lack of properly qualified local health officials. Although it properly has been said that disease germs have no respect for municipal boundaries, it does not necessarily follow that all health work must be organized on a state-wide basis. Crime, fire, and many other services — even highways — are not limited to town or city lines, but for administration, area limitations serve a necessary purpose. The problem is essentially one of

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Meningitis

No. 4

IN SCHENLEY LABORATORIES CONTINUING SUMMARY OF PENICILLIN THERAPY....

Penicillin has a well established role in the treatment of the coccal meningitides. In the meningococcic form the response to penicillin therapy is somewhat slower than following the administration of the sulfonamides; however, penicillin is indicated in instances of sulfonamide-resistance and when patient sulfonamide hypersensitivity exists. In meningitis due to staphylococci, pneumococci, or streptococci, penicillin is the drug of choice.

As soon as the diagnosis is established, penicillin therapy should be instituted in doses of 20,000 to 40,000 units every two to three hours by the intramuscular route. Treatment should be thorough, and should be continued until all signs and symptoms of the infection have been absent for seven to ten days. Since penicillin administered systemically does not penetrate the subarachnoid space, intrathecal (intraspinal, intracisternal, intraventricular) administration is also required. Ten thousand units in 10 cc. of isotonic solution of sodium chloride should be injected (after withdrawal of an equal volume of fluid) once or twice daily until the spinal fluid is clear, and for four days thereafter.

When concurrent sulfonamides are indicated, they should be administered in a dosage sufficient to establish a blood level of 15 mg. per cent.

Surgical, supportive, and other measures should be employed when indicated.

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SPINK, W. W., *and* HALL, W. H.: *Penicillin Therapy at the University of Minnesota Hospitals: 1942-1944, Ann. Int. Med. 22:510 (April) 1945.*

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†Quoted from a report by Karl Figley, M. D., Secretary of the American Academy of Allergy.

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STUDY SHOWS "FLU" VIRUS EXISTS IN SEVERAL FORMS

The influenza virus, an almost infinitesimally minute living particle, not only exists in several forms but these forms are quite different and individualistic, as if they were different species of animals. This is the conclusion of Dr. Jonas E. Salk of the University of Michigan from investigations conducted with the aid of the Commission on Influenza of the Army Surgeon General's Office.

Determination of differences between strains is essential for preparation of more effective vaccines.

Since virus particles are too small to be seen differences can be found only in their behavior in certain physiological and chemical tests. It has been recognized for some years that there are two major types — Influenza A and Influenza B. The maladies caused by these are indistinguishable so far as overt symptoms are concerned, but their immunological reactions are quite different. A vaccine prepared from A virus is of relatively little value in protecting a person from influenza caused by B virus. The vaccine used by the Army is prepared from a mixture of both.

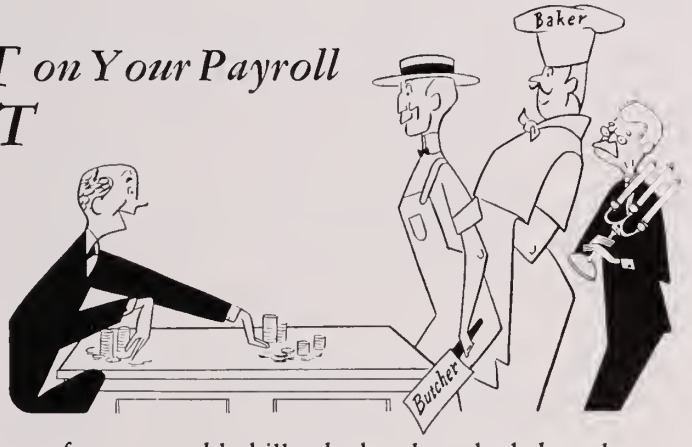
Dr. Salk's experiments show that within these two types there are highly individualistic strains. Since the flu viruses were first isolated several continuous hereditary lines have been maintained at various laboratories. He tested some properties of these strains — especially a blood-agglutinating ability — under various degrees of heat. Heat tends to speed up chemical and physiological processes. Quite marked differences were found.

Like all other living things — it is assumed that the virus particle is living because it possesses the fundamental properties of life — these sub-cellular organisms seem bound by some fairly rigid law of heredity. Differences tend to become stabilized in families and persist.

Techniques evolved for finding these differences promise to be of some value in preparing more effective vaccine, the value of which now has been conclusively demonstrated by the Army's tests with great numbers of men during the last year of the war.

... News Release, Office of Surgeon General, Technical Information Division, Washington.

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PUBLIC HEALTH IN R. I.
continued from page 778

organizing the public health services in a manner which reconciles properly their intimate local characteristics with the limitations which are inherent in the local governments.

Health a State Responsibility

The most simple solution would be to place entire responsibility for all public health services on the state, abolish all local health officers and mechanisms, and direct the state to organize its administrative areas in any efficient way that it deemed proper. Such a solution would mean very little to most of the local governments, except for Providence and the three or four other local communities that make a real effort to maintain some local health service. It probably would result in better service for a considerable portion of the state's total population.

On the other hand, such a solution would be inconsistent with any general policy which aims to strengthen and revitalize the local governments. If state administration is proper for public health, it probably is equally proper for most other services. Furthermore, the advantages which a system of local administration can provide in the way of experimentation with different methods and ideas, and for meeting particular local needs, are worthy of preservation.

To provide a maximum measure of local responsibility, and at the same time provide an economical administrative structure, it should be possible to organize an efficient public health service along more or less the following lines. It may be observed in these several suggestions that except for the organization of the local health units, the theory and practice of the present laws are closely preserved.

(1) The state would continue the following functions.

(a) Complete control of health sciences and trades — as at present.

(b) Complete control over all sanitary measures — this would expand the state's authority over all nuisances and environmental sanitation; abolish all local milk inspection and set up one all-inclusive system; establish the state as the exclusive regulating and enforcement agency for sanitary measures in eating places, hotels, drinking establishments, camps, etc.

(c) The state would continue its present functions with respect to vital statistics.

(d) The state would prepare and promote educational material bearing on public health matters.

(e) The state would have general supervision of local activities in control of diseases and maternal and child health, except as noted later.

(2) The local governments would be responsible, subject to general supervision by the state, for control of diseases; for maternal and child health care; in short, for strictly medical matters; and as at present for the proper recording of vital statistics.

(a) To perform these functions cities and towns having in excess of 25,000 population should be required to employ a full time, properly qualified public health officer, plus such other assistance as may be necessary.

(b) Towns having less than 25,000 population may join with other cities and towns for the purpose of establishing a joint board of public health and employing a full time qualified public health officer, providing that the total population of the group so uniting shall not be less than 25,000; and providing also that any agreement for uniting with any group of cities or towns shall be for not less than a three year period. If any town fails to join any such group, the state shall provide such services and charge the local government its fair share of the cost.

Would Broaden Service

Such an arrangement, insofar as it is reasonably possible, would make available to every city and town the services of a full time health officer. It would mean eight health officers in the seven cities and the one large town, East Providence, having populations in excess of 25,000. For the remaining 175,000 of the total state population in thirty-one towns, an additional number of health officers, probably not more than four or five, would be employed. Competent authorities have expressed the opinion that every community of 25,000 people or more should have a full time qualified public health official.*

Although there are various details to be considered in working out such a plan, it is desirable for the purposes of this report to keep the discussion on broad issues of general policy. The major endeavor is to provide full time competent direction of medical health services at the level where it is most needed and where the work actually is performed. The smaller local governments cannot afford individually to employ a competent health officer. In the past they have attempted to provide service by employing a local practicing physician on a part time basis. Although there are undoubt-

City Health Administration, Carl E. McCombs, M.D., Macmillan Co., p. 52.

continued on page 784

Because there is striking evidence of nutritional abnormalities . . .*

*Margolis, H. M.: Diagnosis and Treatment of Arthritis and Allied Disorders, New York, N. Y., Paul B. Hoeber, Inc., 1941, p. 59.

Virtually all recently published reports dealing with the treatment of arthritis stress the therapeutic value of *all* the essential vitamins in the management of arthritic patients.

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PUBLIC HEALTH IN R. I.
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edly some favorable examples of this kind of service, the results as a whole have been decidedly unsatisfactory. A part time health officer is likely to find that if he gives the attention to the public service which is needed, he is compelled to neglect his private practice. The common result is that the public service is neglected and consequently the public interest is not properly protected. Unless some arrangement is adopted by which the small units of local governments can pool their resources, it is almost inevitable that the state will be forced to accept the entire responsibility.

Proper Organization Important

The proposal herein made for local health services would increase costs in all but four or five communities for the simple reason that very little if any service is now being provided. Some savings would result from the elimination of the local milk inspectors and the several local laboratories. The state also should be able to reduce its appropriations on those services which would be taken over by the local governments, though the state would continue to maintain certain supervisory services, and the net saving in cost would not be important. The fact is, however, that health expenditures are now being wasted by being spread too thinly over an unworkable organization, and a relatively small increase in expenditures with a proper organization should produce a superior return for the dollar expended.

Other health problems outside of those heretofore discussed merit consideration.

(1) The Charles V. Chapin Hospital as at present operated is not properly a city function. Originally many communities established so-called "pest houses", later changed to "isolation hospitals" or "contagious disease hospitals." Today the Chapin Hospital operates not only as a contagious disease hospital serving the entire state because of its superior facilities, but also as a tuberculosis and a psychopathic hospital. Recently it has added surgery to its list of facilities. The state has assumed certain responsibilities in the field of hospitalization at both Howard and Wallum Lake, and there is little valid distinction between those institutions and the Chapin Hospital. Earlier opposition to the state taking over the Chapin Hospital was voiced on the grounds that it would place the hospital "in politics." Such specious arguments should not be permitted to stand in the way of this desirable move.

(2) The state maintains a separate division for policing and regulating the sale of narcotic drugs. The Federal government performs a similar service, and the possibilities for abandoning this special service in Rhode Island might be explored.

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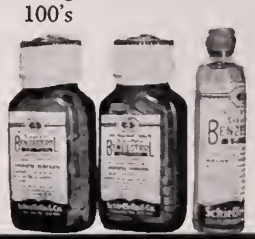
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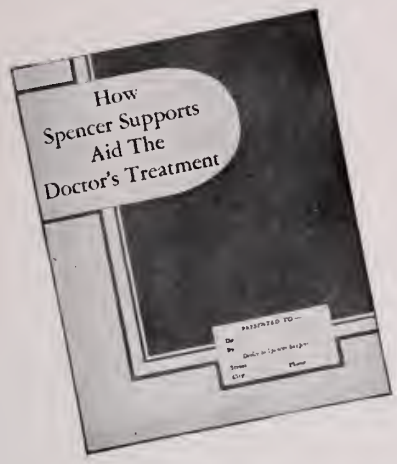
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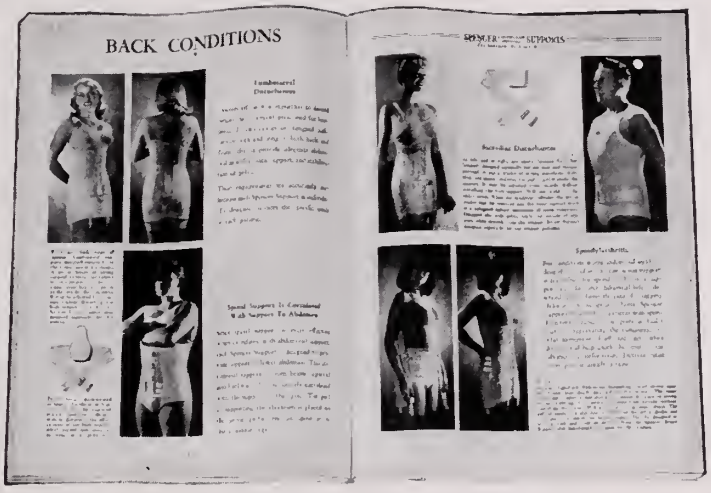
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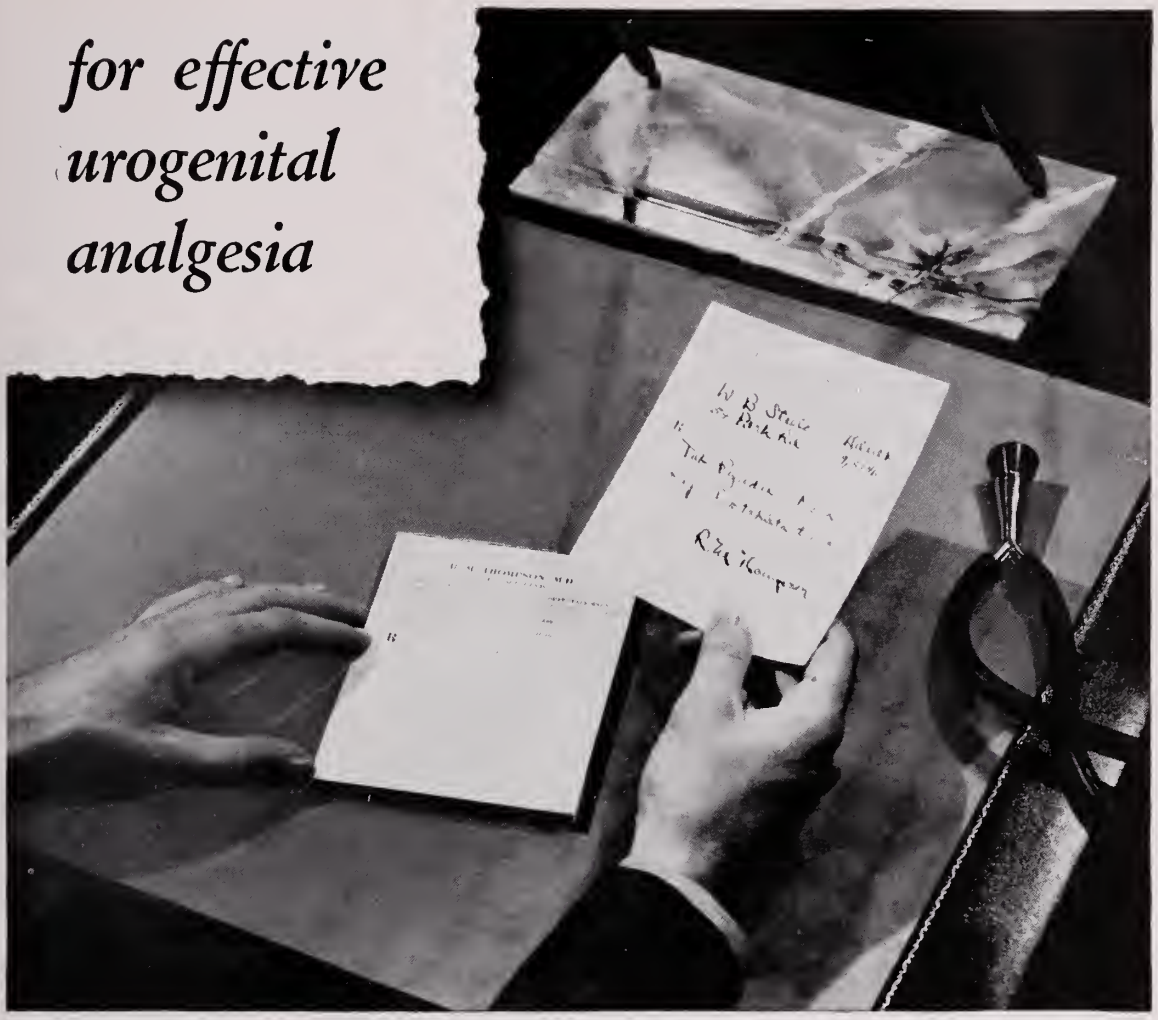
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continued on page 790



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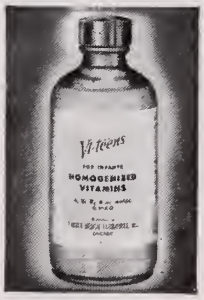
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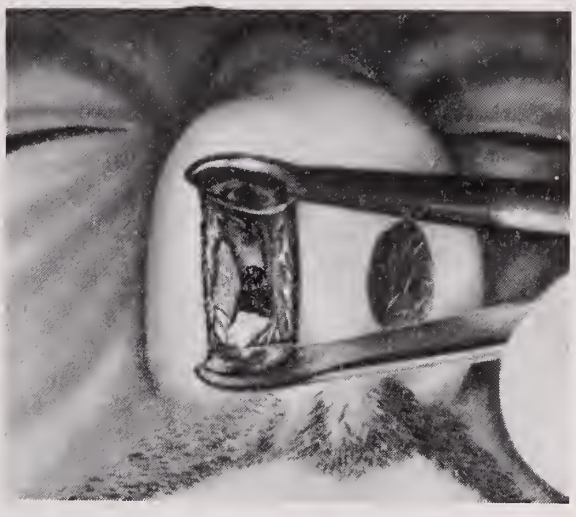
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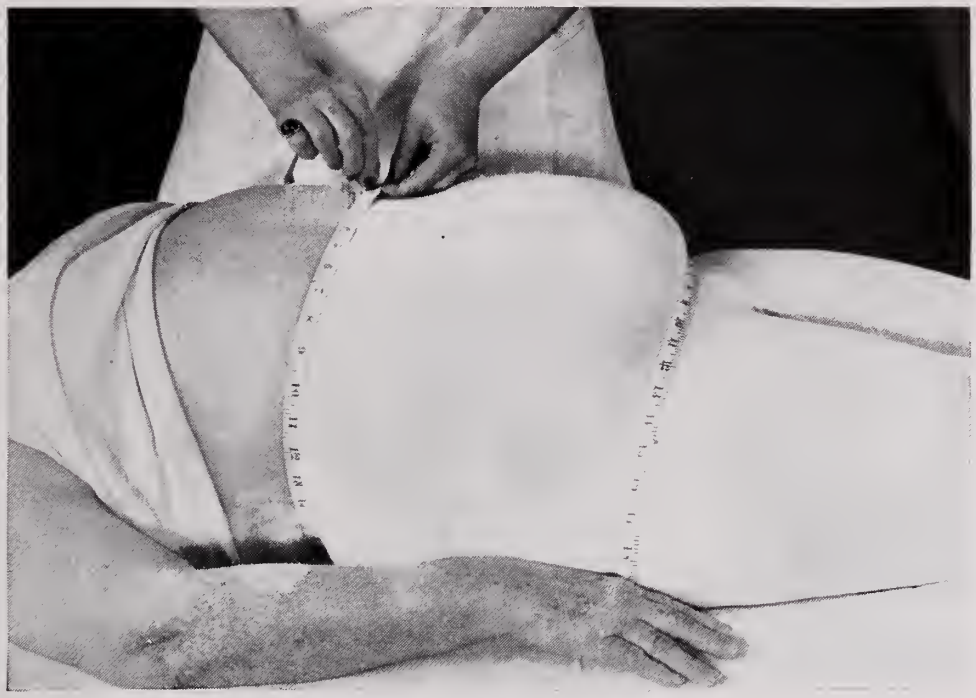
1. Am. J. Dis. Child. 66:1 (July) 1943.

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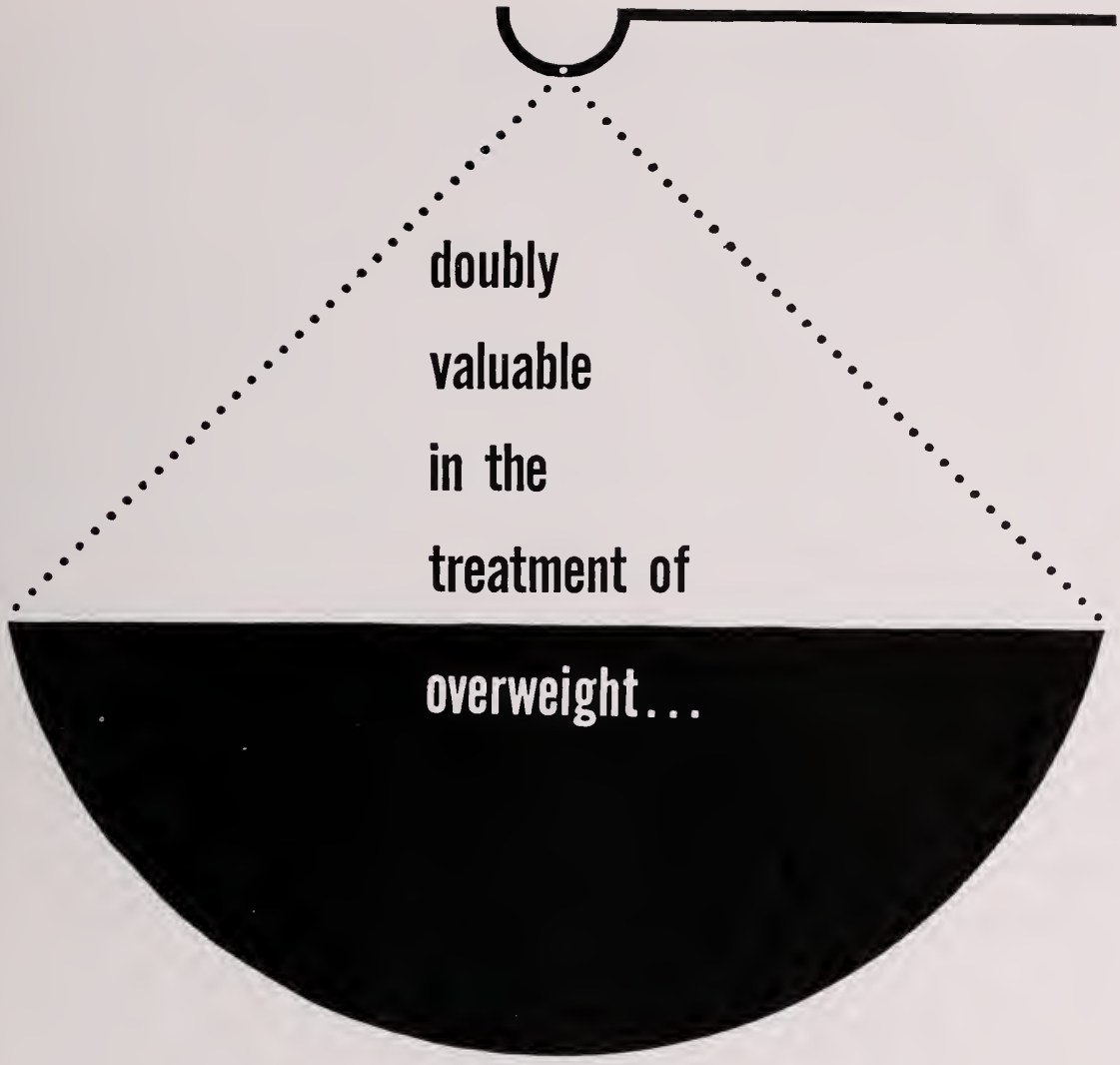


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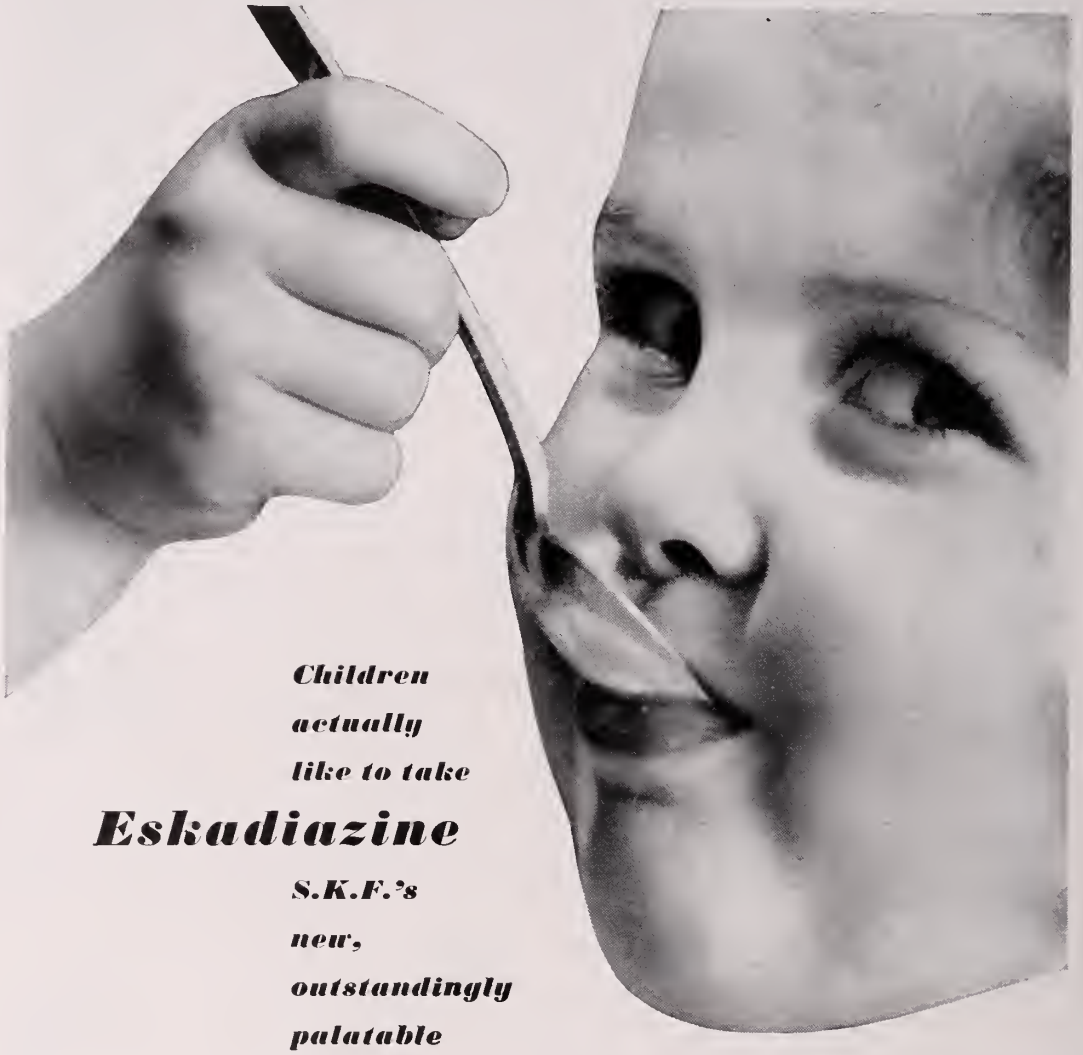
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*Flippin, H. F., et al.: Am. J. M. Sc. 210:141-147, 1945.

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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



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Volume XXIX, No. 11

Contents Page 815



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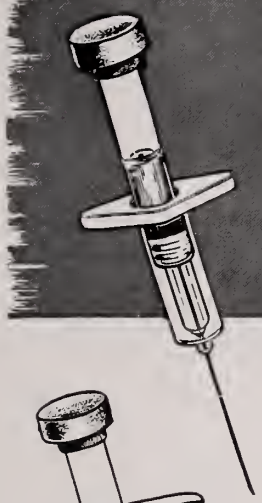
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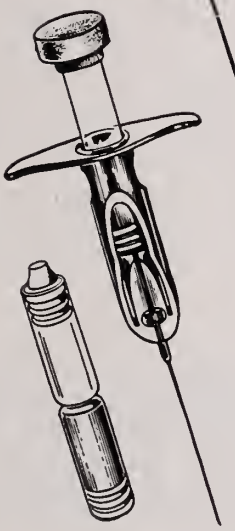
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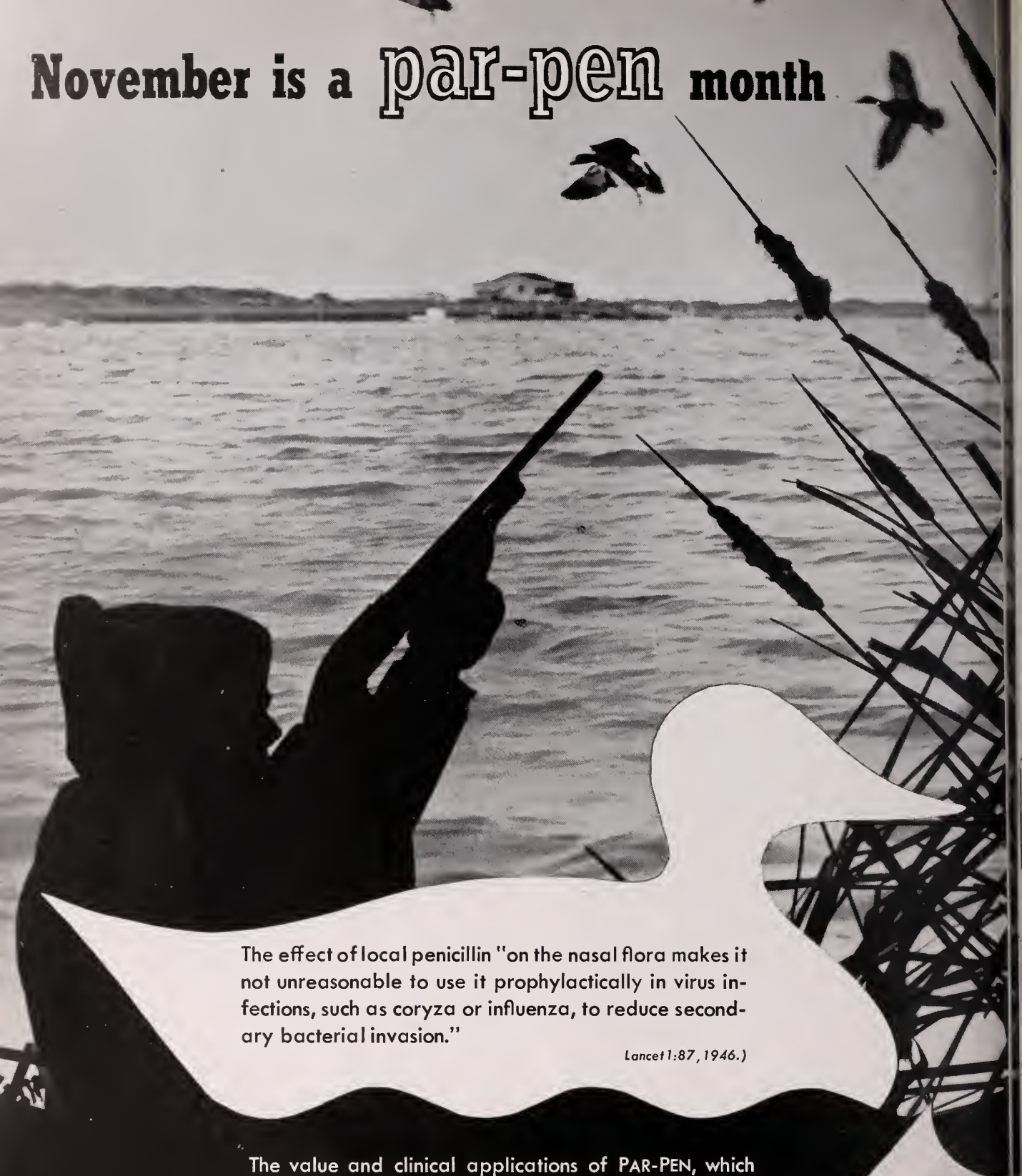
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1. Moore, C. U., Brodie, J. L., Thornton, A. J., Lesem, A. M., Cordua, O. B.: Failure of Abundant Sunshine to Protect Against Rickets. Am. J. Dis. Child., 54: 1227-28, (Dec.) 1937.

2. Follis, R. H. Jr., Jackson, D., Elliot, M. M., Park, E. A.: Prevalence of Rickets in Children Between Two and Fourteen Years of Age. Am. J. Dis. Child., 66:1-11 (July) 1943.

3. Kugelmass, I. N.: Newer Nutrition in Pediatric Practice, p. 656, Lippincott, Philadelphia, 1940.

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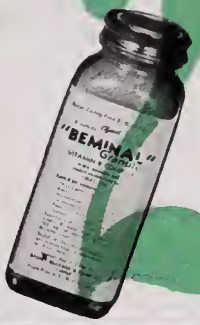
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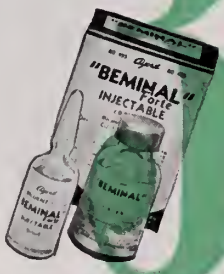
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1. Am. J. Surg. 44:288 (April) 1942.

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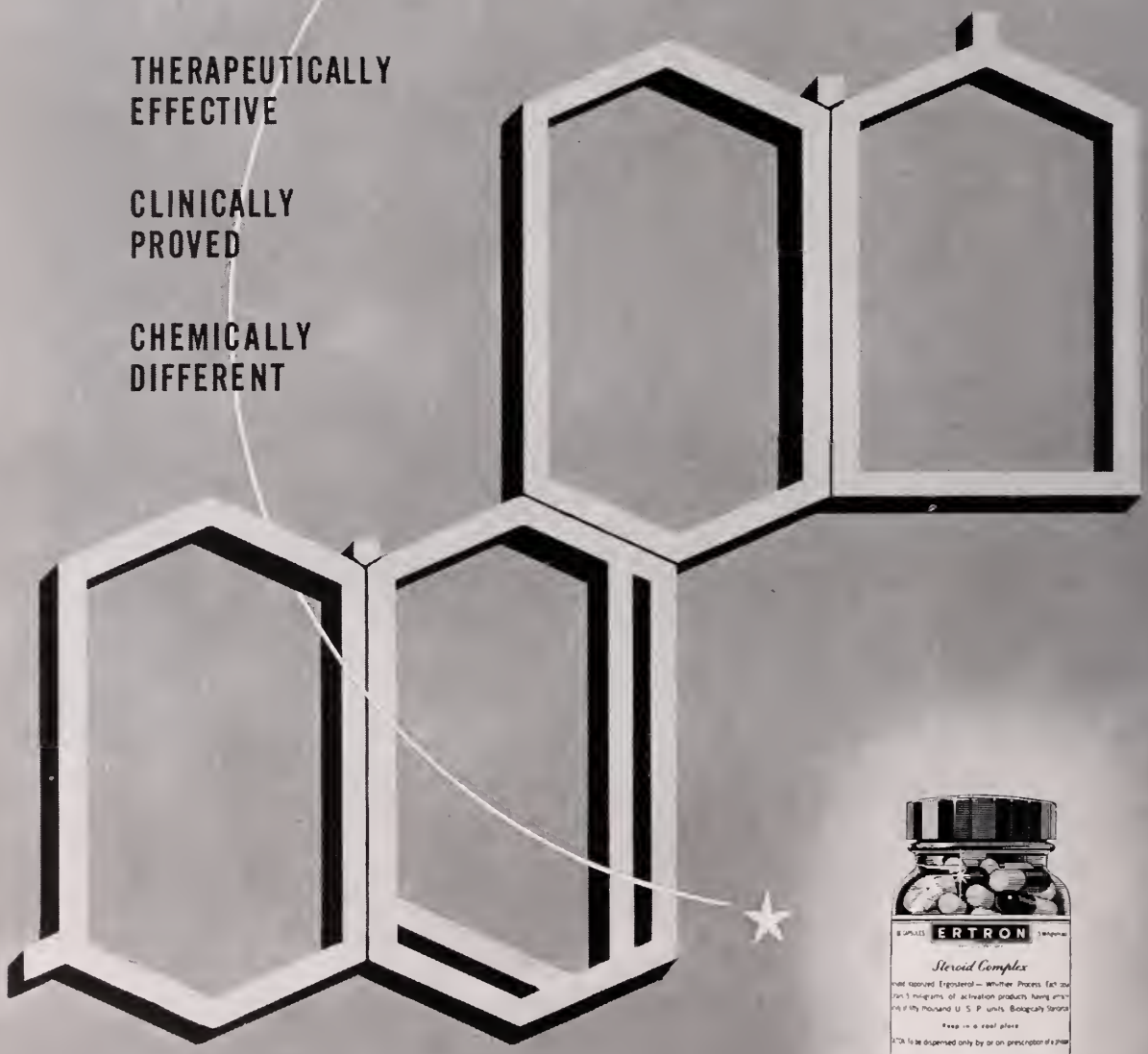
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A picture of The Good Samaritan provided the inspiration that



eventually led to the founding of Eli Lilly and Company

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXIX NOVEMBER, 1946 NO. 11

MANAGEMENT OF THE CONVULSIVE CHILD*

CHARLES BRADLEY, M.D.

The Author. *Charles Bradley, M.D., Superintendent, Emma Pendleton Bradley Home, East Providence; Instructor in Pediatric, Tufts College Medical School, Boston.*

THE purpose of this paper is to stress the importance of the physician's responsibility for enabling the convulsive child to live the fullest, happiest life possible. This implies a great deal more than merely prescribing a medical regime designed solely to eliminate the convulsions themselves. These implications can probably be discussed most clearly if they are introduced by briefly mentioning such facts about convulsive disorders as are most pertinent to the treatment described later.

A convulsive child may be defined as a boy or girl who is subject to recurrent convulsions. To the best of my knowledge, exactly the same simple definition adequately describes the "epileptic child." A convulsion is, of course, only a symptom. As such it indicates that portions of the brain are being influenced by whatever pathological process or disease entity is responsible for this particular symptom. However, a "tendency to convulsions" or "epilepsy" should not be thought of or discussed as a specific disease, particularly as one that must always be mentioned in hushed tones, shrouded in mystery, or thought of as a disgrace and the inevitable cause of an unhappy, unproductive life.

Electroencephalographic and other investigations[1,2] indicate that convulsive symptoms are the result of simultaneous discharges of impulses from masses of neurons within the brain structure. What actually causes masses of neurons to discharge their energy paroxysmally in certain individuals is as yet not completely understood. We know that certain pathological conditions, such as intracranial tumors or other sources of pressure, direct injuries to the brain, some metabolic disturbances such as occur during hypoglycemia or in nephritis, may precipitate the nervous discharge which results in a convulsion. Since all patients suffering from such conditions do not have convulsions as symptoms, the evidence is strong that an underlying predisposition toward convulsions is more fundamental to their appearance than mere precipitating causes. This predisposition or "low convulsive threshold" may be detected even in the intervals between seizures by newer diagnostic techniques, particularly the electroencephalograph.[1, 2, 3]

Varieties of Convulsive Phenomena

Convulsions themselves may take a variety of forms, complete classifications and descriptions of which may be found elsewhere.[1, 2] To most physicians grand mal seizures, primarily a motor expression of the convulsive tendency, are quite familiar. To physicians who see any numbers of children petit mal attacks, characterized by brief interruptions of consciousness and evidenced by such slight obvious disturbances as momentary change of expression, blinking, or interruption of activity, are likewise quite familiar. Both of these convulsive patterns are easy to recognize if directly observed. Each has its own characteristic electroencephalographic outline, so specific as to be diagnostic in doubtful cases. Medications most likely to influence favorably the further recurrence of each type of seizure are available, at least as starting points in their treatment. Less frequent varieties of convulsions call for consultation with specialists, both for diagnosis and treatment.

Dramatic and inconvenient though a child's convulsions may be, the clinician who is conscientiously interested in the broader aspects of his patient's entire welfare will wish to understand the personality and capacities of the convulsive child in order

continued on next page

*Presented before the Rhode Island Medical Society at its 135th Annual Meeting, at Providence, May 15, 1946.

to guide him and his parents so that a practical and constructive regime of daily life may be prescribed along with his medicine.

There is no unanimity of opinion as to whether children subject to convulsions show any very common characteristics in their personalities. The writer's experience with large numbers of ambulatory, intelligent convulsive children sharing with other patients the full and active life of a children's psychiatric hospital, free from community prejudices and parental worries, has convinced him that the personal characteristics and problems of most convulsive children are very similar to one another if one knows what to look for. Moreover, these characteristics distinguish most such patients from their non-convulsive brothers and sisters prior to entering the neutral environment in which they have been observed. Sudden variability in mood with impulsive actions and periodic, apparently unprecipitated irritability are notably conspicuous. Physical hyperactivity and restlessness are almost as prominent. The attention span is apt to be short and power of concentration poor. In school arithmetic is most likely to be the subject presenting exceptional difficulty. No one of these symptoms is, of course, specific for an underlying convulsive disorder, but their combination is so frequent as to be impressive. They are also seen in children with electroencephalographic patterns of typical convulsive form even when the seizures themselves are of rare occurrence or have apparently never been observed clinically.[4, 5, 6] This suggests that repeated disturbance of the brain physiology which we can record electrically even though we do not understand it provides an "organic" or "constitutional" basis for the behavior of such children regardless of their other life experience.

Quite apart from the "convulsive behavior" suggested above, any boy or girl whose life at home or in a community is punctuated by repeated seizures meets and reacts to the attitudes of others with extremes of behavior which are in no way characteristic of his illness and vary to degrees which are influenced by the child's personality and the way he and his seizures are handled. This type of secondary reactions to a convulsive disorder is by no means characteristic of the symptom or the illness which produces it.

Steps in Complete Treatment

The physician who is faced with the supervision of the convulsive child and who wishes to help him in all phases of his disorder will be guided toward the solution of the problem by a fairly orderly series of steps. With due apologies for oversimplification, these may be listed as follows:

1. He will definitely rule in or rule out the presence of a convulsive disorder in his patient.
2. He will evaluate the susceptibility to convulsions, if present, in terms of its being on the one hand symptomatic of some potentially dangerous disease "such as may require neurosurgical attention" or on the other hand as merely a recurrent symptom whose main significance is that of a social handicap which excludes the child from many normal children's activities.
3. He will at this point not forget that the essential aim of his medical care is a happy, useful life for the child.
4. He will prescribe treatment appropriate and and adequate for the control of the individual child's particular type of seizures but will not overdo this at the expense of his patient's personal efficiency.
5. He will keep in mind that we now have available drugs in addition to those that are used to control seizures which may facilitate the child's social adjustment.
6. He will try to see that his patient throughout childhood can share in a full and stimulating program of activities, which are an important basis of later mental health and economic efficiency.
7. He will not neglect the guidance of the child's parents, family and teachers.

Each of these steps and a few miscellaneous suggestions not fitting into the above scheme will now be discussed.

Ruling in or ruling out seizures. Since any child may show reactions suggesting true convulsions or behavior reminiscent of what has been described above as characteristic of convulsive disorders, the physician must first of all determine whether or not he is dealing with a true convulsive disorder. In evaluating the authenticity of seizures themselves, it is helpful to obtain as full a description of a number of them as possible, usually from the parent. This includes the frequency, time of occurrence, consistency of pattern, and sequence of events in the seizures. If observing parents are encouraged to furnish complete descriptions of what has happened without the necessity of being influenced by too many suggestive or leading questions, the history alone should be quite conclusive. In the author's experience young children are rarely capable of (or interested in) simulating what occurs in a true convulsion with any consistency. The unconscious imitation of seizures on an hysterical basis is theoretically possible, but certainly most unusual in children. A description of the child's general behavior and school accomplishment in terms of

the peculiar characteristics mentioned above often helps confirm or disprove whatever evidence is otherwise presented for a convulsive disorder.

All of us who have hoped to observe children's seizures in the office or on a hospital ward know that the physician is unlikely to see a convulsion except by rare chance. This is particularly true of grand mal attacks. In come children petit mal seizures may be precipitated if the child is induced to overbreathe rapidly for a minute or so. In others the same result may be obtained by encouraging the youngster to focus his attention very fixedly on a small object, such as a pencil point, which is moved slowly toward and away from his face, the technique being reminiscent of what is used by popular hypnotists in public presentations.

The most reliable single test for the presence of a true convulsive disorder is the electroencephalogram.[1, 2, 3] It certainly should be used in any case where there is reasonable doubt as to an accurate diagnosis. Unfortunately, this is not a simple or brief procedure. It requires a careful placement and fixation with collodion of electrodes at specified points on the patient's scalp and their subsequent removal after examination, both of which take time. This and the operation of the apparatus while tracings are being taken require experience, particularly in restless children. In competent hands, however, the pathological tracings diagnostically specific for certain types of seizures (mainly grand mal and petit mal) may be secured, not only during actual attacks but in the intervals between them and even in some children with behavior characteristics of the convulsive type in whom seizures themselves have rarely or never been observed.

Pneumoencephalography in which spinal fluid is withdrawn and replaced with air or gases, so that by contrast the actual shape of spinal fluid channels and the brain itself may be recorded by x-ray, is a hospital procedure. It involves time and expense, is certainly most uncomfortable, and under certain conditions potentially dangerous. Since alterations in the shape of the brain itself or in the spinal fluid channels give no significant correlation with brain function and are no measure at all of convulsive tendencies or behavior characteristics, pneumoencephalography has no place in routine or preliminary studies of the type we are discussing.

Evaluation of convulsions as possible signs of conditions dangerous to life. If preliminary investigation indicates that a convulsive disorder is present, the physician must make sure that it is not due to a progressive neurological disorder which unless interrupted by surgery or other physical treatment will progress and threaten the patient's life. Convulsions may be the first recognizable clue in the detection of such conditions. Such clues are practically most significant if descriptions of the seizures themselves, physical or neurological examination, or the electroencephalographic pattern suggests a focus of activity or damage such as might be produced by an intracranial tumor, hematoma, depressed fracture, localized physical trauma, etc.[1] Additional clues to progressive space occupying lesions are evidences of increased intracranial pressures, such as repeated headaches, projectile vomiting, or choked optic discs. If the underlying condition is progressive, one would expect an increase in the severity or frequency of the attacks or changes in their pattern. The ultimate diagnosis and treatment of such conditions is a neurosurgical problem. It is here that pneumoencephalography or ventriculography has a definite and important purpose to serve. The family physician and pediatrician may wisely refer such specialized investigation and, of course, any neurosurgical treatment to specially experienced neurosurgeons and their technical assistants.

Although certain metabolic disturbances may have as an early manifestation convulsions, this is not frequent in conditions other than renal damage, insulin shock, etc., most of which are usually self-evident from other angles. There is a possibility that seizures in some children may be precipitated by hypoglycemia, and a standard glucose tolerance test is a useful adjunct to investigation in such cases.

Seizures in the majority of convulsive children are not precipitated by pathological conditions amenable to surgical or metabolic treatment. The common main threat to most such patients are the disadvantages attendant about continuation of the attacks themselves. Injury during a convulsion is a potential danger but does not compare to any degree with the handicap of being excluded from large areas of normal childhood life. In such cases treatment may not be necessary to save life itself but is certainly essential to making life worth living.

Aim of treatment. Having necessarily concerned himself with the clinical details of careful and accurate diagnosis, the physician may well stop at this point to remind himself of the long range aim of constructive treatment for his patient. It is very easy in following enthusiastically investigations of specific causes to forget that the object of treatment is the child and not his symptoms. Complete focus on the attacks themselves, either by physicians, parents, teachers, or others, is certain to produce an atmosphere of invalidism and morbidity about any boy or girl. Treatment which sponsors overprotection, self-centered preoccupation with feelings of being abnormal, or deprivation of participation in most childhood activities is not conducive to

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a happy, full life. With too much protection, important and stimulating life experiences are missed. If there are too many special regimes of rest, diet, and other restrictions, either rebellion or "enjoyment of ill health" is fostered, and exclusion from school and community activities undermines the self-confidence, self-esteem, and feelings of security that are so necessary to the development of a well balanced personality. The physician must not in his enthusiasm to control the seizures use preparations or doses which produce irritability, fatigue, or poor coordination quite outweighing any advantages of freedom from attacks. At the other extreme he may neglect medication and naively and incorrectly assume that by telling parents that their child "will outgrow his spells" that he is in some way being reassuring and offering constructive guidance. It is perfectly true that many children who have suffered from convulsions in early childhood do without specific treatment spontaneously remain free for long periods or indefinitely in later life. In most children with recurrent convulsions maturity itself does not bring complete protection, and even if it did the intervening years spent in waiting for the child to grow up may be wasted by the occurrence of occasional seizures which exclude the child from any sort of happy existence.

If by eliminating the possibility of serious underlying pathological conditions and controlling seizures themselves insofar as possible the child has been adequately treated, he should then be allowed to lead as full a life as his condition and the community permit. This can be a great deal broader than most parents and physicians suspect.

Medication to control seizures. Convulsions are such dramatic symptoms and so strongly influence the attitudes of those about the child that their control is quite important apart from its possible aid in eliminating severe attacks in which injury may occur or are attended by confusion and disorientation which are temporarily crippling. These facts are well recognized by all except those who are content to stand idly by and wait for nature to help the child "outgrow his attacks."

In children who are subject to grand mal seizures the initial drug of choice is dilantin (sodium 5,5-diphenylhydantoinate) [1,7] a barbiturate which in itself is not a sedative. It has a specific depressing effect on stimulation of the motor activity which produces grand mal seizures. Since this medication does not become effective until the body is saturated with it and single large doses do not cause sleep or other unwanted disturbances, the daily dose may be given all at once. This daily dose in children runs from 1½ to 6 grains, usually best given with an ample drink or fluid or after a meal to obviate possible gastric irritation. It is wise to start with small doses, increasing at sufficiently long intervals so that some record of its effect on eliminating seizures may be accurately observed. In the few children who have a sensitivity towards this drug a transient rash, usually morbilliform, may be noted but which is not a contraindication to continuing medication. It is well to remember that with dilantin, as with other barbiturates, a common first symptom of overdosage is ataxia, susceptibility to which varies in different children. Prolonged use of dilantin may result in hypertrophy of the gums resembling that seen in scurvy, and reasonable attention to oral hygiene with daily massage of the gums should be prescribed as a matter of routine where this drug is used for any length of time.

Within very recent months another barbiturate available under the name of tridione (3-5-5-trimethyloxazolidine-2-4dione) has been introduced.[8,9] It has a rather specific and dramatic effect on the seizures of most children suffering from petit mal attacks. This barbiturate has in addition soporific qualities and is best given in divided doses. It, like dilantin, becomes effective only as the body becomes saturated with it. An adequate starting dose is .3 grams three times daily. Both dilantin and tridione are at present available only in capsule form, which introduces certain difficulties in its administration to small children. Opening the capsule and mixing its contents with soft foods, such as mashed potato, jellies, etc., is an effective way of giving it to patients who are unable to swallow capsules.

For over thirty years the conventional drug of choice in this country for convulsive disorders has been phenobarbital. Doses of ⅛ to ½ grain three times daily are usually adequate in younger children. Since large single doses produce drowsiness, the daily ration is best divided. Workers at the Emma Pendleton Bradley Home have for some time been impressed by the fact that in spite of the efficiency of phenobarbital in controlling seizures, particularly of the grand mal type, it very frequently has an unfavorable effect on the ability of children to make a good social adjustment especially in terms of increased irritability, activity, and aggressiveness.[10] Phenobarbital is available in elixir form and usually comes in small tablets, so that it is easier to administer to small children than the preceding preparations.

For a great many years prior to the discovery of phenobarbital the bromides were used (and abused) in the control of convulsions. Their soporific effect, salty taste, tendency to accumulation, and slow excretion are definite liabilities. However, sodium bromide may be employed judiciously in convulsive children who react poorly to the various barbiturates. Doses of 5 to 15 grains three times daily are roughly clinically equivalent to what was suggested in the preparations mentioned above.

All these drugs are for continued use and must be given regularly and without interruption if they are to be effective. They do not usually exert their full effect until from one to three days after they are first administered and if suddenly withdrawn are apt to precipitate seizures two to three days after the last dose is administered. Because of this any shift from one medication to another is best carried out gradually over a week or ten-day period. None of these preparations are very effective as emergency treatment for individual seizures. In reasonable dosage each may be employed almost indefinitely without adverse effect on health or mental development.

If emergency treatment becomes necessary to terminate prolonged seizures which are resulting in extreme fatigue and threatening life, sedatives which are prompt in action are essential. Since such treatment is indicated only in extremes, large doses should be given, and the fairly short duration of action of most of these preparations is a safety factor under these circumstances. Nembutal (pentobarbital sodium) by mouth or rectum, either in capsule or elixir form, is usually effective in doses of from 1½ to 3 grains. Puncturing both ends of a capsule before administering it assures the promptest possible absorption. Chloral hydrate in relatively large doses of 5 to 15 grains in water or saline by rectum may be more effective than nembutal but is theoretically not quite as safe. Paraldehyde has an unusually wide margin of safety, but its unpleasant odor precludes its use if other drugs are available. If the physician is called out to see a convulsing child in person, he will probably find inhalation anesthesia the quickest and surest means of terminating the attack. Clinical caution must be used in administering ether or chloroform to a child whose condition because of prolonged convulsions is desperate.

A few patients, notably girls in adolescence or later life, may have a fairly regular cycle as to the occurrence of their seizures. Where this is recognized, increasing the usual maintenance dose for two or three days at the time of menstrual periods or when otherwise indicated may be extremely helpful.

Medical control of behavior difficulties. At times the behavior of certain convulsive children may present far more serious problems than do their seizures. It has been reported that some of the anticonvulsive drugs themselves not only reduce the liability to seizures but also result in a greatly improved social adjustment. This has been an unusual occurrence in the experience of workers at the Emma Pendleton Bradley Home, where all medications are given as a matter of routine with no suggestions to the children as to what the possible effects may be and with no changes on the part of adult attitudes which might be a factor in such improvement. Certain of the frequently used anticonvulsive drugs, notably phenobarbital, often result in irritability and aggressiveness, particularly if given in sufficient dosage to induce drowsiness.

Improved social adjustment following the administration of benzedrine sulfate (racemic amphetamine sulfate) has been reported in significant numbers of hospitalized problem children.[11] This medication has apparently no effect on the occurrence of convulsions and does not significantly alter any abnormalities in the electroencephalographic pattern.[10] It is in no way specific for the type of behavior difficulties encountered in children who are subject to convulsions but has been noted to have a dramatic effect on their general adjustment, as it has in a number of other clinical conditions. Its most striking results are reduction of the variability and impulsiveness so prominent in convulsive children, with increase in attention span for and application to scheduled and planned activities, especially in the school situation. In one study notably improved efficiency in arithmetic was apparent in many children.[12] The results observed in using benzedrine in young children differ from those commonly reported in adult patients, where general stimulation is a frequent effect. Since benzedrine has a tendency to produce insomnia, it is often a valuable adjunct to the large doses of true sedatives, such as phenobarbital, bromides, and tridione, when amounts of these drugs necessary to control seizures tend also to produce drowsiness. Theoretically benzedrine is contraindicated in diseases of the circulatory system, particularly hypertension and arteriorsclerosis, but otherwise has a wide margin of safety as far as true toxic effects are observed. Full adult doses produce the most striking effects in children and there are few contraindications except impairment of appetite. A morning dose of 10

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PHYSICIAN-VETERAN LISTINGS

To the listing in the October issue of the JOURNAL of Rhode Island physicians honorably discharged or on terminal leave from the armed forces who have resumed private practice the following should be added:

BARONIAN, D. RICHARD
688 Cranston Street, Providence 7 WI 3310

MARKS, HERMAN B.
183 Angell Street, Providence 6 UN 1020

RUISI, JOSEPH L. C.
41 Grove Avenue, Westerly Westerly 2575

SWEET, GUSTAF, M.D.
105 Waterman Street, Providence 6 GA 1979

to 20 milligrams daily with a second dose of approximately half this amount at noon, if the effect wears off through the day, may be used over long periods of time if necessary.

The more recently introduced isomer of benzedrine, dexedrine sulfate (dextro-amphetamine sulfate), has about the same effects as benzedrine with approximately half the dosage required. It may be substituted if the large doses of benzedrine impair appetite to any appreciable extent. In a large series of children at the Emma Pendleton Bradley Home who have received both benzedrine and dexedrine at different periods a fairly striking individual preference for one drug or the other has been noted but is as yet unexplained.[13] In office practice where parents are apt to become agitated if appetite is impaired, dexedrine may logically be tried as first choice. Both of these drugs produce results only on the days when they are given, and undesirable side effects of decreased appetite, insomnia, or palpitation are usually much more prominent the first day or two than after continuous administration.

Neither form of amphetamine has any permanent effect on neurological activity or personality adjustment. However, if a convulsive child has been getting into difficulties because of his compulsive, erratic behavior or has been failing in school because of impaired concentration, the administration of a medicine which results in improved social adjustment and school accomplishment will in the long run result in a feeling of confidence and self-assurance, which are an efficient introduction to subsequent successful social and school accomplishment. Incidentally, the dramatic improvement particularly in the school situation of some children who have previously chronically presented problems in spite of good intelligence is very apt to result in new and improved attitudes toward the child by his teachers and schoolmates.

Full program of activities advisable. It is a natural tendency on the part of most parents and some physicians to advise extra rest, freedom from competition, and a protected existence for children whose convulsions may expose them to injury in falls during attacks, confusion in busy traffic, etc. It is a common observation that such children become more active and distractible for periods immediately preceding their seizures, especially those of the grand mal type. For years the inference has been drawn that excitement and fatigue have precipitated the seizure that usually follows such behavior. Experience at the Emma Pendleton Bradley Home with convulsive children whose activities are not restricted indicates that this hyperactivity is indeed a prodromal symptom, almost part of the convulsion itself, and that the child is happier and certainly much less difficult to handle if allowed full activity at such times. Most convulsive children who are allowed to be busy and active have less severe and less frequent seizures than when they are greatly restricted and so protected that their major preoccupation is their own illness.

It is good practice to tell parents that allowing a child complete participation in whatever activities are available will insure his growing up to the fullest capacity in spite of what other handicaps may remain. By overprotection the actual chance of accident or injury may be slightly reduced, but the net result is a chronic invalid who even if his medical treatment is eventually successful will be left with a feeling of having missed forever a great many desirable childhood experiences. It is to be hoped that the regulations of school systems may progressively be improved as enlightenment on this whole subject becomes dissipated, so that full participation in many activities from which convulsive children are now excluded, especially those of a physical nature, will be encouraged. There is still an unfortunate tendency in many systems to emphasize the possible injury to the child and subsequent complaints or even lawsuits from the family at the expense of what will be most constructive for the child himself and actually reduce the frequency of his seizures.

Parental guidance. The parents and families of a child who is subject to a poorly understood, desperately feared, chronic illness in which the stigma of something "mental" may be attached will flounder in their attempts at any consistent approach to the youngster. Physicians can do a great deal to remove the mystery and fancied stigma from illnesses characterized by convulsions. The answering of questions frankly and in simple language is a great help. There is rarely any reason for avoiding telling parents just what medication is being used and in what dosage. Good judgment by the physician in the words he uses to describe the disorder may be extremely reassuring, whereas the careless use of terms such as "epilepsy," "deterioration," "abnormality," and a multitude of others may produce such anxiety in the parent as to remove the possibility of any equanimity toward the subject or the patient. There are now readily available several excellent publications for the layman explaining the significance of seizures and the methods used to control them[14, 15, 16]. They are written by physicians who are experts on the subject and may be used most effectively to supplement the personal explanation and answers to questions willingly and frankly supplied by the family physician.

Two nation-wide organizations of laymen[17, 18] are doing a great deal to dispel the mystery, fear, and stigma attached to a diagnosis of epilepsy, and

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NEURO-PSYCHIATRIC DISORDERS, OFFICE AND HOSPITAL TREATMENT*

HUGH E. KIENE, M.D.

The Author. *Hugh E. Kiene, M.D., of Providence. Former Clinical Director, Rhode Island State Hospital for Mental Diseases; Director, Psychopathic Department, Charles V. Chapin Hospital; Member, Neurological Out-Patient Department, R. I. Hospital.*

THERE IS, at present, a big demand by the public for neuro-psychiatric treatment. This demand must be met. Curtailing the work done before the war in the then existing facilities is not an answer to the present problem. It is essential that those suffering from neuro-psychiatric disorders receive adequate medical care. There are personnel shortages in psychiatric hospitals. A patient suffering from a disturbing psychiatric illness, one in which his behavior is such that hospitalization is required is not provided for unless committed as insane to the State Hospital due to curtailed admissions in other hospitals. The same shortages in help are present in the State Hospital for Mental Diseases, but to date, it is possible to commit a patient suffering from mental disease to this institution.

It is with reluctance that the patient, family and physician accept commitment of a patient as insane in order to obtain treatment. There are many mental conditions in which the illness is acute and carries a good prognosis. Commitment of such cases to the State Hospital is not the answer to the present problem. Formerly, he could be sent to the Charles V. Chapin Hospital on a Temporary Care Paper and there receive treatment, which in most instances would return him to his family and society, or, he could be sent to Butler Hospital and receive there the treatment he required.

The State Hospital, where he can be sent, is faced with the same shortages in help as are other psychiatric hospitals, so that when the patient is committed as insane to the State Hospital, it is difficult at present to be certain he will receive the treatment he needs. The doctors, nurses and medical aids at the State Hospital are more than over-burdened with routine administrative matters, supervision of eating and sleep of the patients, and meeting at least minimum requirements in their clinical records.

It is against the principles of sound medical practice to condone substandard treatment, and the physician cannot be satisfied with anything short of first-class medical care, no matter what the existing circumstances may be. The physician's first obligation to his patient is that of service and insisting that proper treatment which the condition calls for be given.

The purpose of this paper is to make suggestions for meeting this situation, particularly in reference to work done in the office. In the first place, emphasis must be made on early treatment, especially in the psychotic reactions such as manic depressive psychosis and schizophrenia. The suggestions to be made apply particularly well to the treatment of the involutional melancholic. When the patient shows evidence of mental disease of a psychotic nature in his symptomatology, prompt treatment before his symptoms become too disturbing, will do much to keep him in his home. It is usual that the physician is consulted after the psychosis has been allowed to advance to the stage where hospitalization is required. The patient is, in his psychosis, unable to cooperate sufficiently to follow through adequate office treatment. Under these circumstances, his admission to a psychiatric hospital is indicated. There, with treatment, the asocial symptoms subside, and he can be returned home in a remission. As with many illnesses, a remission may be partial or complete. It is not enough merely to discharge the patient home as he may have a relapse and his illness advance again to the point where his readmission to a hospital is indicated. It is possible, in many instances, to follow a patient in the office after he has reached a stage of remission, and, in this way, prevent a relapse by additional treatment when there is a tendency for the psychosis to recur. A careful follow-up, seeing the patient regularly, going over his mental health with him, and also his family, will often prevent the need for readmission to a hospital. The purpose of early treatment is to gain the cooperation of the patient in following through what is necessary to relieve him of his mental illness and keep him well.

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*Presented before the Providence Medical Association, at Providence, October 7, 1946.

During the past ten years, there has been developed a method of treatment called electro-convulsive therapy. This is given with a machine very carefully manufactured to eliminate hazards of giving electricity. This electrical treatment has been found especially effective in the involutional melancholias, but has also been used with benefit in many cases of schizophrenia and manic depressive psychosis. The number of treatments required in these conditions varies greatly. From eight to twelve electro-convulsive treatments is thought necessary in the average case of involutional melanchoia, whereas in some cases of schizophrenia, benefit will be obtained even after twenty treatments. The treatment of a case of involutional melancholia will best indicate the method of approach to this disorder. This man was in his early fifties. He was agitated and depressed. He threatened suicide and his thoughts were self-condemnatory. It was believed unsafe to treat him outside of the hospital, so he was admitted and there given eight electro-convulsive treatments with definite improvement. He was advised to report regularly at the office, but failed to do this and his family did not keep in touch with the physician. There was a relapse and the initial symptoms of depression returned. Treatment was started, after the importance of follow-up was carefully explained to the family, and he was given eight more electro-convulsive treatments with a satisfactory result. He continues to be followed at two-week intervals, and, with a continuation of his remission, this interval will be increased to once a month, and then, perhaps, once every several months, but always at a preappointed time.

Now, to give the case of a young woman in her thirties who was catatonic, and, therefore, considered in need of hospital care as she did not eat properly or take an adequate amount of fluids. She was given twelve electro-convulsive treatments in the hospital, recovered from her stupor, and was about to return to work. There was some delay in her return for follow-up examination, and, when she did come to the office, she was again in a catatonic state. But, this time, rather than re-admit her to the hospital, because the hospital was so crowded, and was refusing admissions, her treatment was started in the office with the result that she responded, coming out of her catatonic stupor after six additional treatments.

A milder mental disorder, that of anxiety hysteria, in a woman in her twenties, was treated with psychotherapy, which was not successful as the patient was inaccessible. She was inclined toward panic and had some depressive thoughts that treatment would be of no avail and her condition was hopeless. A combination of psychotherapy and medication did not relieve her condition. After consultation, it was decided that electro-convulsive therapy should be tried in order to make her more accessible for psychotherapy. There was a prompt response in this case and only six treatments were necessary to make her cooperative for psychotherapy.

A paranoid forty-seven year old patient with symptoms of depression was admitted to the hospital. She received Insulin shock treatment, and, as there was no great improvement, electro-shock was given. She improved and was able to be discharged from the hospital only to have a relapse after a few months. Her mental symptoms were sufficiently active for readmission to the hospital. Again, she received electro-convulsive therapy with a rapid response and a satisfactory remission. She was followed regularly in the office, and when symptoms again began to appear, relief was obtained by 4 additional treatments.

In the office, electro-shock treatment is given twice weekly. A physician, medical technician and several medical aids are in attendance. The disadvantage of electro-shock treatment given in the office is that the family are more directly a part of the treatment program. The disadvantage of electro-shock treatment given in the office is that when admitted to a hospital, the patient is removed from social environment. He is not required to meet usual social adjustments. A routine is followed and most of the decisions are made by the hospital staff. The situation met is not ever-changing, it is always under control.

There are certain precautions to be taken before electro-convulsive therapy is started. Of primary importance is a careful physical examination. With this, an electrocardiogram is often required. And, to be further assured that the patient's condition is satisfactory, an x-ray of the heart may be of value. Before the treatment is started, consultation with an internist is considered important. The contraindications for electro-convulsive therapy vary according to the severity of the illness and the need for treatment; also, the attitude of the relatives and the patient concerning the mental disease and whether or not they are cooperative in sharing the risk entailed. Ordinarily, if there is no organic disease of the brain and if the heart is functioning normally, the treatment is without much danger. Where the patient's suffering and the family's concern are sufficiently great to demand shock treatment, it has been given in coronary disease, in arteriosclerotic Parkinson disease, in asthmatics, and in rather severe hypertensives, care always being taken not to minimize the risk involved in the case complicated by organic disease. It is essential at all times to keep the family well informed concerning the risk involved. If the risk is considered great, it is a wise policy to insist that the patient be admitted to a hospital for treatment.

Elecro-convulsive therapy has been given with success in the home. There, of course, it is necessary to have the complete cooperation of the family. In one case, a young woman in her twenties had been in the hospital where a diagnosis of mixed psychoneurosis had been made with a question of schizophrenia. She was not given treatment in the hospital as she improved without it, and was discharged home. She was seen in the office and at first it appeared that the diagnosis of psychoneurosis was the correct one. But, on subsequent visits, it became apparent that her illness was, in reality, schizophrenia. Treatment was commenced in the office, but due to the extreme resistance of the patient, this was impossible. Arrangements were made for her admission to a psychiatric hospital to continue treatment, but the family were reluctant to have her readmitted, and requested that, if possible, they would appreciate the treatment being given in their home. This was done, and after three treatments, the patient became sufficiently cooperative to carry on the remainder of the treatment in the office.

So far, the discussion has largely centered about the administration of electro-convulsive therapy, both in the hospital and office. It is to be remembered that E.C.T. is only one form of treatment for certain neuropsychiatric disorders. In the greatest number of such disorders therapeutic aids are of first importance. Without going into the ways and means of psychotherapy, which is always given, we will go on to psychotherapeutic aids. —

First comes a well-regulated program. This should be a general program, a weekly program and a daily program. The simplicity of the program is of value. A certain time for rising in the morning, a set time for meals during the day, a full work day, and then, not to be forgotten, organization of leisure time. Attention to leisure time will do much to modify an emotional reaction. Sometimes, it is wise to find out by actual tests the patient's aptitude and interests. When this has been accomplished, the patient is advised to follow-up on these aptitudes and interests. Aptitudes are a means of directing leisure time endeavors. Music, art, and interest in nature are often recommended. Regular church attendance is of therapeutic value, as it is possible through religion to obtain a feeling of security which makes the patient independent of undependable sources of satisfaction. In a like manner, nature is everywhere and there is so much to be gained by a fundamental interest in things natural. It might be said that a test of the patient's independence is his willingness to attend church alone without having to have someone with him as then he relies only on the sense of his nearness to God.

Another measure which is employed to make the patient accessible for psychotherapy is narcosynthesis. This consists of administering intravenously sodium amytal or sodium pentathol, and thus, by removal of conscious resistance, the underlying thoughts and feelings become available to be better understood by the patient. Narcosynthesis was used extensively in the Military Service to aid those who had developed marked fear reactions in combat, with periods of amnesia as an escape from their frightful experiences. It was found by giving these sedatives intravenously to be possible for the men to re-live, under controlled conditions, their combat experiences and make them better able to understand the mechanism causing their mental disorder.

Another treatment which found popularity during the War by its use in military personnel is what is called modified insulin treatment. This is effecacious in psychoneurotic mental disease in which there is a concomitant loss of weight associated with the other symptoms, usually anxiety and fear. This treatment is a hospital procedure as there is need for nursing care and close observation for a period of three to four hours. Insulin is given intramuscularly, starting with twenty units and increased ten units daily until sixty units are given. After the daily insulin injection, the patient rests from three to four hours during which time he becomes ravenously hungry; then, a high carbohydrate meal is given. After a period of approximately two weeks, in the average case, there is accomplished a gain in weight approximating the patient's average weight. With this improvement, there is associated a decrease in anxiety and the fears become less intense. Of course, psychotherapy is given with the modified insulin treatment and a well-regulated daily program carried out.

What have been briefly mentioned in this talk are a few of the approaches to the treatment of functional neuro-psychiatric illness, most of which can be practically administered in a well-organized office. It is possible to obtain adequate assistance to carry out these treatments. There is an advantage in office treatment in that the patient-physician relationship, which is so important, is maintained.

It is to be hoped that what has been said will help to make clear a few methods by which the functional neuro-psychiatric patient can be made advantageously assisted.

PROVIDENCE
MEDICAL ASSOCIATION

Next Meeting

MONDAY, DECEMBER 2

MANAGEMENT OF THE CONVULSIVE CHILD

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they deserve the encouragement and support of individual doctors and organized medicine.

Additional miscellaneous facts. There are several important considerations which have not lent themselves to grouping under any of the preceding headings. A frequent question is, "How long will my child have to take medicine for his convulsions?" A practical rule which gives a definite answer to this question is to continue regular medication in full dosage for a period at least two years following the last seizure. After this if all goes well, the dosage may be gradually reduced over a period of months, but should any evidence of seizures recur smaller maintenance doses may be kept up indefinitely. It will reassure parents if they are given specific information of this sort, and they may also be assured that intelligently adjusted, medically supervised administration of the proper drugs will have no harmful effect on the central nervous system or mental development, either temporary or permanent.

It is of the utmost importance to emphasize to parents and children alike that medication must be given regularly without interruption. The temptation to give adequate amounts only for brief periods after a child has been upset is particularly to be deplored. Continued medication for children's convulsive disorders is insurance against seizures, and like insurance is not effective if it has been allowed to lapse.

Certain diets have been found helpful and have enjoyed some popularity at various period because of their effectiveness in controlling seizures. The ketogenic diet[19], composed of proportions of fat very large in comparison to carbohydrate and protein, produces chronic ketosis which has been proven effective in reducing or eliminating petit mal seizures in some children. This diet, however, is expensive, distasteful over long periods, and must be carried out meticulously if it is to be effectual. It has become far less popular as newer potent drugs have become available and as physicians have become aware of the value of giving treatment which can be administered in a casual matter-of-fact way, which is rarely possible with any special diets.

A diet containing as little fluid as is compatible with good health definitely reduces the tendency to convulsions in children and adults.[20] It is difficult to administer effectively in children due to the ever present sources of water in this country, and children who become thirsty readily avail themselves of fluids from nearby puddles and even toilet bowls. A dry diet with limitation of fluid is a practical adjunct to the treatment of convulsive disorders in older children, adolescents, and adults who are sincerely interested in improving their condition and will voluntarily conscientiously follow instructions. This can hardly be expected in small children.

Unless the convulsive child suffers from such metabolic disorders as diabetes or nephritis which require dietary treatment, there is no indication for other specific diets to favor the elimination of the convulsions. The necessity of focussing on any special diet tends to foster a feeling of invalidism and egocentricity in any child. The rebellion which special diets in children often engender makes additional problems for their harrassed parents. Since there are no logical grounds for special diets apart from those mentioned, there is no point in prescribing "a little extra fat in the diet," "bacon every morning for breakfast," or "avoid red meat in the diet," or similar suggestions of which these may be reminiscent.

Medications which are useful in terminating exhausting seizures as emergency treatment have been mentioned, and beyond their enumeration there are few actual procedures which one should recommend to a family. A considerably abused form of treatment is to place the convulsing child in a tub of what is supposed to be warm water. No doubt, if properly carried out, this may have a sedative effect which is helpful, but anyone who has had to treat the serious burns that not infrequently result from the hasty and impulsive immersion of a convulsing child by distracted and desperate adults will lose enthusiasm for this particular recommendation. Mouth gags to be pried between the teeth in order to prevent the child from biting his tongue probably produce more damage to teeth and gums than they prevent. They are very apt to be applied after the teeth have been clenched in the original tonic phase of a grand mal seizure, too late to do any good. The use of anything other than soft material, such as rolled bandage, for this purpose is definitely contraindicated. Although physicians know that individual seizures usually run their own brief course without resulting in extreme exhaustion, one must be sympathetic with the fact that the parents of a convulsing child are often desperately in need of something to do which at least they feel may be helping the situation and that a great deal of experience is necessary to merely stand by with composure. It is certainly good advice to suggest putting the child to bed where in his convulsive movements he cannot injure himself. There is usually no objection to suggesting giving an enema, which may be actually helpful and certainly will keep the anxious onlookers busy until the convulsion subsides spontaneously.

Placement away from their own home of children who have frequent seizures is quite difficult to secure. If the child is mentally defective and

convulsions are an added symptom, the outlook for completely successful rehabilitation is poor and referral to a state school may be recommended as much for the relief of the family as the good of the child. Any of the good private schools for mentally retarded children are of necessity expensive and only a few will accept children who have convulsive disorders. Many of the better private boarding schools will accept occasional convulsive children, particularly if the seizures themselves are well controlled medically and the social adjustment is reasonably adequate. In some cities provision is made for convulsive children in special classes or special schools in the public school system, the famous White School in the City of Detroit being an outstanding example.

The more sound information that is disseminated by the medical profession and by informed laymen among educators and school administrators the sooner will educational opportunities for convulsive children approach any degree of adequacy. Teachers who have had experience with convulsive children and have been neither discouraged by the experience nor dismayed by the prospect of more will certainly agree with conclusions drawn at the Emma Pendleton Bradley Home, where for over fifteen years a certain number of convulsive children have been under treatment with other patients requiring neuropsychiatric therapy and where the staff have always treated the occurrence of seizures with the greatest equanimity. When this is done other children, even those who are themselves disturbed or unstable, show little interest and no agitation when convulsions occur and carry on their school work or other activities without interruption.[21]

The emotional tone of some homes is such that the convulsive child is adversely affected by attitudes and tensions which defy control. Placement of the patient elsewhere, at least temporarily, may result in improvement of his symptoms. Many parents are under additional stresses beside those resulting from their children's convulsions and cannot profit from even the best and most painstaking guidance. If medical treatment of children under the care of such parents is not effectual, both the child and the parental attitudes may profit from special hospital treatment although permanent results are hardly to be expected unless some provision is made for helping the parents in the absence of the child. There is hope that in the not too distant future new children's psychiatric hospitals may be available where the convulsive child may receive sound medical treatment, education, and training while the parents obtain simultaneous treatment and instruction through periodic contacts with members of the staff.

If family physicians and pediatricians will acquaint themselves with the information now readily available regarding children's convulsive disorders, they should be able to handle such situations with assurance and confidence. The most successful therapists will keep in mind most of the various aspects of the whole problem which have been discussed in the preceding pages. If so, treatment of a convulsive child may always be undertaken with optimism. When one realizes that in the area of drug therapy alone dilantin, benzedrine, dexedrine, and tridione have become available only within the last ten years, with their assurance of wider and brighter horizons to many children who previously would have been left to "outgrow their spells" after previously available treatment had faltered or failed, one can conceive how inappropriate it is to base any discussions of this whole problem on the gloomy clinical traditions of twenty-five, fifty, or a hundred years ago. It is in no way consoling to parents nor constructive for their children if the physician adopts a gloomy, pessimistic attitude toward a problem where he should have so much to offer. If either experience or disposition makes optimism and enthusiasm impossible, he should refer his convulsive children and their parents to someone who can supply these very necessary ingredients to sound and successful therapy.

Summary

In the preceding discussion the need for recognizing convulsions as only one symptom of a variety of underlying conditions is stressed. It is urged that the patient himself rather than his symptoms alone be the object of treatment. A discussion of the personality characteristics fundamental to convulsive disorders in children is presented. An orderly sequence of steps in the diagnosis and treatment of convulsive children is discussed, with special emphasis on the newer drugs available for the control of various types of convulsions and their attendant behavior disorders, the desirability of a wide program of activity for the patient, and the importance of constructive attitudes on the part of physicians and parents.

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OSTEOPATHY IS NOT MEDICINE

THE recent publicity given the efforts of Blue Cross in Rhode Island to include the services of osteopathic physicians in the prepaid voluntary surgical insurance plan developed by the Rhode Island Medical Society illustrates once again the general lack of public knowledge relative to the scientific basis for osteopathy which is opposed to the theory of medicine as taught and practiced by doctors of medicine.

Andrew Taylor Still, born in Virginia in 1828, founded osteopathy in 1874, and his theories form the basis and foundation for the teachings of the practice in all osteopathic schools in the country. In his own words he set forth the basis of the system of osteopathy as follows:

Our Platform

It should be known where osteopathy stands and what it stands for . . . Our position can be tersely stated in the following planks:

First. We believe in sanitation and hygiene.

Second. We are opposed to the use of drugs as remedial agencies.

Third. We are opposed to vaccination.

Fourth. We are opposed to the use of serums in the treatment of disease. Nature furnishes its own serum if we know how to deliver them.

Fifth. We realize that many cases require surgical treatment, and therefore advocate it as a last resort. We believe many surgical operations are unnecessarily performed and that many operations can be avoided by osteopathic treatment.

Sixth. The osteopath does not depend on electricity, X-radiance, hydrotherapy, or other adjuncts, but relies on osteopathic measures in the treatment of disease.

Seventh. We have a friendly feeling for other non-drug, natural methods of healing, but we do not incorporate any other methods into our system. We are all opposed to drugs; in that respect, at least, all natural, unharmful methods occupy the same ground. The fundamental principles of osteopathy are different from those of any other system and the cause of disease is considered from one standpoint, viz. disease is the result of anatomical abnormalities followed by physiological discord. To cure disease the abnormal parts must be adjusted to the normal; therefore other methods that are entirely different in principle have no place in the osteopathic system.

Eighth. Osteopathy is an independent system and can be applied to all conditions of disease, including purely surgical cases, and in these cases surgery is but a branch of osteopathy.

Ninth. We believe that our therapeutic house is just large enough for osteopathy and that when other methods are brought in just that much of osteopathy must move out.

It is significant to note that the seventh plank clearly sets forth osteopathy as different from and independent of any other system of healing, with the fundamental theory that disease is the result of anatomical abnormalties.

Such is the theory of osteopathy. Such was the scientific thesis behind the system that was author-

ized by license in Rhode Island when the General Assembly in 1914 enacted legislation which defined the practice of osteopathy in this state as

> "the treatment by manipulation of diseased or abnormal conditions of the human body"...

and also provided that

> "such certificates (to practice osteopathy) granted without examination (for osteopaths practicing in the state prior to December, 1912) shall not authorize the holders thereof to practice surgery, obstetrics, or to prescribe drugs."

For thirteen years osteopathy continued its course in Rhode Island under this legislative authority. Then in 1927 the first amendments were made at the request of the osteopaths, presumably to widen their scope of practice, although there is no record of evidence ever being presented to substantiate their claim of ability to broaden their field of professional work. The amendments tactfully omitted the original definition of osteopathy from the books, and substituted an all-inclusive provision that

> "a certificate to practice osteopathy shall confer upon the holder thereof, the right to practice osteopathy in all its branches as taught and practiced in recognized colleges of osteopathy. The holder of such a certificate shall have the same registered with the clerk of the city or town wherein he resides; he thereby becomes a registered physician, subject to the same duties and liabilities and entitled to the same rights which may be imposed by law or regulation upon physicians of any school of medicine, except the writing of prescriptions for drugs for internal medication, and the practice of major surgery; provided, however, any holder of a certificate to practice osteopathy who can satisfy the board of examiners that he has completed one year post-graduate internship in a hospital approved by said board, may be granted a license to practice any branch of surgery."

Also

> "All applicants for certificates to practice osteopathy shall conform with the same regulations, concerning examination, pay the same fees and be examined in the same subjects prescribed by the state board of health for the issuance of a certificate to the practice of medicine and surgery, substituting in such examination the theory and practice of osteopathy for questions pertaining to the theory and practice of medicine. The examination in the theory and practice of osteopathy shall be conducted by a member of said board of examiners who is a doctor of osteopathy."

Just what was meant by these amendments?

Did the wording "the right to practice osteopathy in all its branches as taught and practiced in recognized colleges of osteopathy" infer, as osteopaths would have people believe, that the practice of medicine is a phase of osteopathy? If such a conclusion could be drawn, then the teaching of law or any other profession in an approved osteopathic school could become legally a branch of the practice of osteopathy — a ridiculous conclusion, to be sure.

Did the statutory wording that the osteopathic physician upon registering his certificate in the city or town in which he intends to practice, thereby making him subject to the same duties and liabilities and entitled to the same rights which may be imposed on the doctor of medicine, mean, as osteopaths would have people think, that the osteopath is a doctor of medicine? We think not, and we are certain the courts would bear out our contention. Osteopathy is still drugless by this amendment, and the rights and duties imposed by law on the doctor of medicine are common to everyone who will heal, they are merely the duty to report births, deaths, communicable disease, etc., and the right to hold oneself out to the public as licensed and authorized to treat disease, pain, injury, etc.

Does the amendment imply that the osteopathic physician may practice minor surgery? Apparently it does, since the restriction is placed on major surgery. But what constitutes minor surgery? and why is it that the state authorities, from the Governor down, have failed to secure from our Supreme Court a clarification of this terminology? And what is osteopathic surgery? Manipulative only? or did the General Assembly in 1927 have in mind the use of instruments for cutting procedures, at a time four years prior to the incorporation of an osteopathic hospital in Rhode Island where such procedures, if permissible, might be done?

Did the provision that osteopaths be examined in the same subjects as doctors of medicine, substituting in such examination questions on the theory and practice of osteopathy for questions on the theory of medicine, establish osteopaths, as they would have people believe, on the same professional basis as doctors of medicine? We think not, for the subjects for examination for all healers are the basic ones of anatomy, physiology, chemistry, pathology, bacteriology, hygiene, public health, etc., and the amended statute definitely provided for the substitution of osteopathic theory for materia medica.

In 1940, at the time when the Basic Science law was enacted whereby the standards were raised for all persons who would practice any phase of the healing art in Rhode Island, the General Assembly enacted an amendment to the osteopathic law whereby the restriction relative to the writing of prescriptions for drugs for internal medication by osteopaths was removed, and the section relative to examination was amended to read as follows:

> "Section 12. All applicants for certificates to practice osteopathy shall conform with the same regulations concerning pre-medical education and examination and shall pay the same fees and be examined in the same subjects prescribed by the board of examiners of the department of health for the issuance of a certificate to the practice of medicine and surgery. The board of examiners in osteopathy shall cooperate with the board of examiners in medicine in giving the same examinations to candidates for license to practice osteopathy as are given to candidates for license to practice medicine and surgery and shall, in addition thereto, give an examination in the

continued on next page

theory and practice of osteopathy. The boards shall give the same recognition to approved osteopathic institutions and organizations as is given to approved medical institutions and organizations."

Just what is meant by this amendment?

The statutes relative to doctors of medicine require that the applicant for licensure be a graduate from a medical school in good standing. There is no provision relative to pre-medical education as that is established by the medical school in its requirements for admission. The 1927 statute referred to above provided for the same fee, and examination in the same subjects, with special examination in the theory and practice of osteopathy.

What is new is the requirement that the board of examiners in osteopathy "shall cooperate" in giving the same examinations to osteopathic applicants for license as are given to doctors of medicine. Was it not the intent of the General Assembly, having granted to osteopathic physicians the right to prescribe drugs for internal medication, to require that applicants in the future should demonstrate some knowledge of the use and application of such drugs for the safety of the general public?

This Assembly action in the interests of public health and safety in no manner changes the basic theory and practice of osteopathy, nor does it make osteopathy the practice of medicine as understood and practiced by physicians educated in medical schools and hospitals, and licensed by the board of medical examiners, although some osteopaths would create that impression.

Such a claim was clearly repudiated by the supreme court of the State of Kansas in 1938 when it stated that

"Osteopaths, in common with all scientific and professional men, are expected to continue to study, to make progress, to learn more about their profession, and to apply such knowledge in their practice, *but they are still engaged in the practice of osteopathy.*"

What has been written into the statutes relative to licensure for the healing art in Rhode Island will undoubtedly continue on the books. This belief is strongly substantiated by the action of the Health Survey Laws Commission which turned in a loosely knit set of amendments to the last session of the Assembly without giving sound and progressive thought to the clarification and improvement of ambiguous terminology in the so-called medical practice act.

Until the Supreme Court of the state is appealed to, either for an opinion by request, or through a test case to determine the true interpretation of what constitutes the scope of osteopathy, and chiropractic, and what is meant by major surgery, there will continue to be conflicts of opinion, strong debate on legislative proposals involving these particular statutes, and public misunderstanding such as has been exemplified by the recent action of the Blue Cross relative to medical care and osteopathic service.

The people of this State should be clearly informed as to the exact provisions of the statutes governing the healing art, and the scope of practice of each group of licensed practitioners. The members of the Rhode Island Medical Society would certainly look with favor upon action taken by the state director of health, or the governor of Rhode Island, in seeking that clarification from our highest court.

SOCIETY DUES FOR 1947

The action of the House of Delegates at the September meeting in changing the assessment of dues for 1947 to $40 for Fellows of the Society in practice more than a year, and $25 for those in their first year of practice probably warrants some editorial comment.

We could relate at length the many needs for increased funds to permit the Society to do all the many things necessary if it is to keep pace with the present age. We could relate lengthy statistics on how much we pay for golf club dues, and similar luxuries. We could tell what the labor unions demand of the worker of whatever salary range to maintain their organization. But such presentations in our opinion are irrelevant in the consideration of the vital necessity that is apparent to anyone who will study the problem.

The report of the budget committee read to the House of Delegates at the September meeting resulted in an unanimous vote for the increase in the annual assessment. That report presents the situation facing the Society with such clearness that we publish it here as an informative statement far more satisfactory than any editorial comment we might attempt to draft:

"At the request of the Council a budget committee has undertaken a study of the financial structure of the Society for the purpose of determining what steps should be taken to provide a reserve fund to permit necessary expenditures without a special tax upon the membership, to provide an endowment fund which is sorely needed, and to retain and add to the valued staff of employees who might be attracted to positions offering higher remuneration.

"In proposing an increase in dues for next year the Committee is fully cognizant of the many financial requests made upon the members of the Society in the year. It believes, however, that there is no obligation to which the individual member should give greater preference than to his own local medical organization. The Committee also recognizes that a duty cannot be paid in dues alone, but that members must be prepared also to sacrifice time, energy, and even family interests, in furtherance of the Profession to which they have dedicated their lives.

"The Society belongs to the individual member. It is his instrument of contact with his fellow physicians, and likewise his medium by which he may advance his

personal views for the improvement of medical and health care in this State. To achieve its full purpose this Society must be strongly organized, and in the present day struggle for progressive action the Society should not be handicapped by lack of sufficient funds to carry on its work.

"As a non-profit organization the Society is not constituted to accumulate sizable reserves. However, the continued lack of a reserve sufficient to meet vital needs of the organization is readily apparent to anyone who takes time to study the financial structure of this Society. This summer the Board of Trustees contracted for repairs to the Library building that could no longer be neglected. These repairs have been unattended for years because of the lack of sufficient finances to pay for the work. The present re-construction entails costly repair to the roof and the exterior walls, in addition to painting the Auditorium. Many other repairs are needed, as suggested in the comprehensive report of the architect who checked the condition of the building.

"As one of the few medical societies in the country maintaining its own library, open also to the general public as a community service, we should exercise a pride in ownership and in our service to the people of this State. We should see to it that sufficient funds are available each year for the cost of keeping the Library in excellent condition.

"The increasing expansion of the Society as a vital organization in the State, and its supervision and participation in various activities within and outside the Society has placed a tremendous burden upon the executive office. The committee proposes that additional help be provided as needed for the better protection of the public and the profession in the ever widening sphere of governmental, and other, programs involving medical, hospital, and public health care.

"It is difficult these days to foretell what the future may bring. We are presently in the throes of a social-economic movement that may be far reaching in its final stages. We, like other state medical societies, have initiated a plan for the better distribution of the costs of medical care through voluntary insurance on a prepaid basis. But, unlike most other medical societies, we have so far been without finances to undertake the promotion of the program ourselves. This, then, is but another striking illustration of the limitations we have placed upon ourselves by failure to accumulate a protective reserve fund."

THE VOLUNTARY WAY

This is the month for the annual campaign for funds for the community chests of Rhode Island to carry forward the work of 124 agencies engaged in great measure in health and welfare activities.

The occasion is not merely one to remind the public of the importance of these needs, and of the necessity for funds to meet them. The occasion is of greater significance. It serves as a focus upon the basic principle of the American way of life, the spirit of willing and voluntary assistance to a neighbor in distress.

Under the impetus of the war public thinking was channeled further into the belief that dependence upon government was the ideal solution of welfare problems of the individual as well as the community. The increasing number of programs whereby federal grants have been issued — with money claimed directly from the states — to develop local state plans on a financial matching basis should cause everyone to think seriously about the inroads that have been made upon the freedom of life that we claim we treasure. Every yielding to government in such matters is the yielding of a bit more of our personal freedom and dependence upon ourselves and our fellowmen to meet the local problems of the community.

Therefore, to support the Community Chest campaign now, as well as the Catholic Charity Fund Campaign next spring, is to give strong and vigorous endorsement of our belief in the voluntary process. Every contribution is a rebuke to those who would seek to establish a socialistic state in America.

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PRESENT PROBLEMS AND PROCEDURES IN NEURO-PSYCHIATRIC OUT-PATIENT SERVICE*

DAVID G. WRIGHT, M.D.
Chief, Out-Patient Service, Butler Hospital

IT IS my intention to try to convey the present problems and procedures in one Out-patient Service dealing with men and women whose difficulties fall in the field of neuropsychiatry. It is unfortunate that psychiatrists have very seldom been effective in communicating to the rest of the medical profession what things we do know and what we do not, what things we can do and what we cannot. Regardless of the several reasons for this failure, I hope to tell you in an understandable way how we go about treating these persons. Their illnesses are similar to those of a large proportion of any community at any time. Their illnesses, further, are painful in the extreme, chronically crippling, and immensely wasteful of human vigor. They become the agents that generate emotional ills in the next generation. There is no reasonable doubt that they promote prejudice, distrust and un-reason in the society of which the patient is a part. There is, in short, no question of the great human and social importance of these ills.

I hope to convey that there is no question that there are definitive treatments that effect their amelioration, redirection and cure; that such definitive treatments are based on simple and understandable conceptions: and that, like good medicine in any field, cannot be successfully carried out without careful, thorough, objective, time-consuming work.

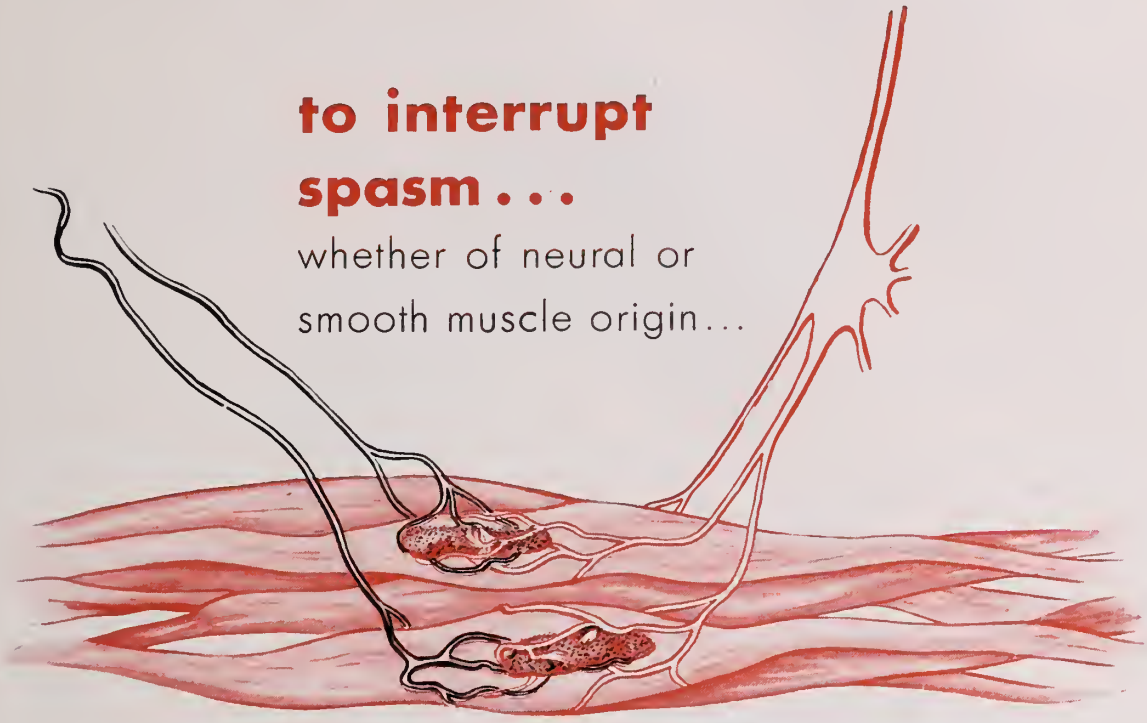
Butler Hospital has always done some out-patient work, which in the past was largely concerned with follow-up and psychotherapy for persons who had formerly been in-patients. The sort of service which it now conducts has long been deemed necessary and there has been during the last year a gradual expansion of its resources for the conducting of a well-balanced Out-patient Service team. This Service is open to any person needing it in the community, not to veterans alone. Since, however, we have a contract with the Veterans Administration, the first large group of patients with whom we have dealt have been veterans. Some of these have been referred by the Veterans Administration, but many, have not been referred by the VA, but have come to the clinic through other channels.

The most important factor in making this set-up effective is the orientation of the Physician-in-Chief of the hospital, whose beliefs give the Clinic its structure and its standards. The Physician-in-Chief has consistently held that there must be no compromise with the highest possible quality of medical and psychiatric practice. He has, therefore, implemented the work by providing whatever resources and facilities seem necessary; by insuring that the physicians on the Service are working full-time over long periods so that continuity of treatment is maintained; by insuring that these physicians need have no other concerns than strictly medical ones in the handling of any case. Whatever time, thoroughness, investigation or money appears useful for the best handling of any patient, is provided. Obviously, holding to such standards makes it possible for only limited numbers to be treated and the Clinic has consistently since its first month, been operating at the limit of its capacity to handle people as we feel they should be handled.

The Service is constituted in the following way. Therapy is done by appointment only, and appointments are arranged as frequently as necessary and

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*Presented before the Providence Medical Association, at Providence, October 7, 1946.



to interrupt spasm . . .

whether of neural or smooth muscle origin . . .

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

PROBLEMS AND PROCEDURES IN NEURO-PSYCHIATRIC OUT-PATIENT SERVICE

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at any time of the day or night that is fitting. Treatment is done by full-time psychiatrists whose staff for investigation and implementing of treatment includes clinical psychologists and social service worker. These physicians use the hospital laboratories, electroencephalograph, consultant specialists in other fields, the occupational therapy shops, and when necessary, the in-patient section of the hospital itself.

The clinical psychologists are employed both for investigative purposes, and in vocational guidance counselling when this is indicated as a part of therapy.

The social service worker, similarly, is used for gathering data for investigations and for helping to alter the patient's environment when that is indicated as a part of treatment.

The consultant specialists, also, are utilized in establishing diagnosis, and in recommending or actually carrying out treatment in their particular fields.

At the same time that psychiatric treatment is carried on, the occupational therapy shops are used as adjuncts to treatment and can, of course, aid in several kinds of ways. They can supply an opportunity for the resocialization of patients who have become unable to function well in contact with other persons; can supply an opportunity for patients to rebuild lost self-confidence in their ability to do a day's work; and, can in certain cases, provide specific retraining in, for instance, hemiparetic and apraxic conditions following head injuries.

Several major industries in the city have worked out with us an arrangement by which special consideration for job placement is given to our recommendation that a patient with a particular training, or with particular talents, is ready to assume responsible work.

We have frequently used the special knowledge or circumstances of certain patients for the guidance, job procurement, and the like, of other patients. We have been able to help patients make plans and obtain work at appropriate times by using the special knowledge of our personnel director, our business manager and our engineer. Several patients have, in fact, been hired for temporary or permanent work in the hospital itself.

Altogether, it is our aim to use to the fullest the resources of all kinds which an institution of this nature provides, and to encourage at all times and in as ingenious ways as possible, inter-personal cooperation and "give and take".

All of this is, of course, secondary in importance to definitive psychiatric therapy. Generally speaking, these adjuncts to therapy give the patient an opportunity to work out in concrete, real situations the redirection of his feelings, which definitive therapy brings about.

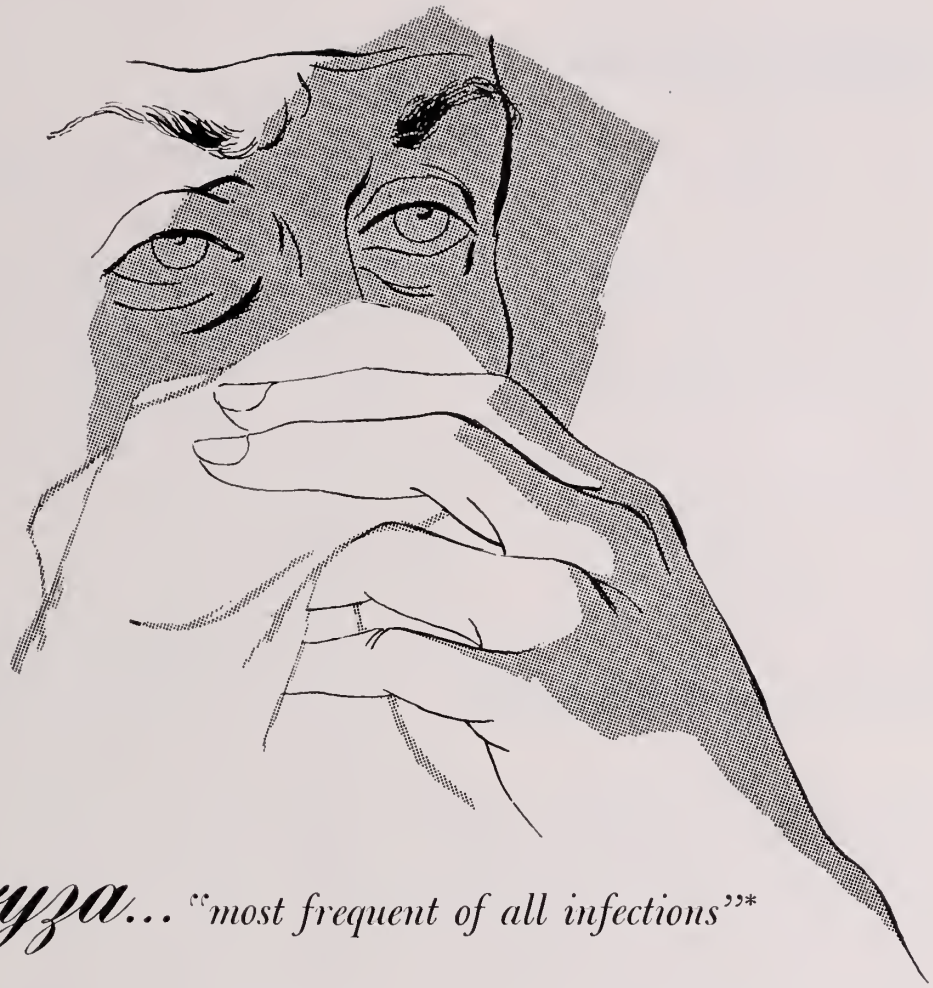
Out-patient staff conferences are held weekly for the detailed discussion of individual cases. These subserve, of course, both a teaching function and a means of arriving at better balanced decisions and more complete understanding of the dynamics of the disturbed feelings in the patient under consideration.

I will present briefly some of the basic data of the Clinic's functioning thus far. Up until the first of September of this year, approximately 150 patients have been referred to us and approximately 900 appointments have been made and kept by this group. While these appointments through the course of actual therapy are usually of an hour's length, the appointments during the period of preliminary investigation and differential diagnosis quite frequently represents many hours, perhaps a full day of work by the laboratory, by the psychologist and by the social service worker. It consumes, roughly, ten hours' work to accomplish the basic investigative procedures which we feel necessary in an uncomplicated case; it consumes a great deal more time in many cases.

With the present Clinic facilities it is possible to carry under active treatment about 60 patients, and this is done. Since these patients are at different stages in treatment during any one month, some are seen several times each week and some are at a stage when they need be seen as little as once a month. The tabulation of the frequency and length of time necessary for adequate treatment is difficult to do without being misleading. It is certainly not valid to draw an average of the number of visits made by the patients who have been discharged as essentially well. There are some who have suffered from illnesses which are simple and rapid of solution. One, for instance, changed from a thoroughly disorganized and disabled person to a happy and productive one after four psychotherapeutic sessions. There are, on the other hand, many whose difficulties are either more deeply rooted or more complex and whose treatment has been equally successful, but has needed eight months and thirty or forty therapeutic sessions to accomplish the desired results.

There are, of course, also a number who cannot at our present stage of knowledge, be treated with anything like as definite success, but who can be kept at a level of marginal adjustment with continuous but, perhaps infrequent, support, so that treatment cannot be said to have a termination or end point.

continued on page 842



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*Birkeland, J.: Microbiology and Man, Baltimore, Williams and Wilkins, 1942, p. 215.

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PROBLEMS AND PROCEDURES IN NEURO-PSYCHIATRIC OUT-PATIENT SERVICE

continued from page 840

Although there are these several patterns which determine the number of visits necessary, it is, I think, safe to say that the most typical case in the group which we have seen thus far is substantially improved both in his inner feelings and in his adjustment to people and to his responsibilities after approximately twenty therapeutic hours.

A meaningful tabulation of "results", of course, encounters the same difficulties, but disregarding those whose improvement is partial for whatever reason, 38 patients of this group have been considered, by very cautious and conservative standards, substantially recovered.

The attitudes developed by the patients in relation to the Clinic has been, on the whole, extremely healthy for the patients and extremely gratifying to us. Fairly frequently patients are distrustful and disturbed by the idea of embarking on psychiatric treatment and by coming to a hospital which they had previously presumed was an expensive series of padded cells. This initial point of view is almost always quickly changed, and the patients almost universally poignantly appreciate the lack of "buck-passing" and "run-around", the directness of the approach, the fact that whatever time is necessary is spent by the physician paying attention to the matters that loom large in patients' minds, the thoroughness of medical and laboratory investigation, and the cooperative "give and take" situations in which the adjunctive treatments put them. As I shall try to point out later, the development of such attitudes is not simply pleasant for them, but is a very potent and specific therapeutic tool.

As to the way in which the patient group is constituted thus far, at least 90% have been veterans of the Armed Services in this war. The ages, therefore, are for the most part between 19 and 35 years. About one-half of them are married and about two-thirds of them are employed. The majority of them have survived actual combat experience. Many were discharged from the Service without ever having presented themselves as medical or psychiatric problems in the Service.

An evaluation of their adjustments to life before the time of military service indicates that well over two-thirds of them could be considered severely or moderately predisposed to later emotional disturbance. This does not mean that such an overwhelming majority were in any sense inadequate, ill, or dependent individuals before their military service. In the service, and particularly in combat, many had extraordinarily good records from the point of view of skill, dependability, responsibility and gallantry in action. As I shall try to point out more precisely later, circumstances in the military set-

continued on page 845

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Scarano, J. A., and Coppolino, J. F.:Arch. Pediat. 54:97

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PROBLEMS AND PROCEDURES IN NEURO-PSYCHIATRIC OUT-PATIENT SERVICE

continued from page 842

ting or in the return to civilian life, usually acted as specific traumata, hitting specific vulnerable spots in the feelings of the individual, and by so doing reactivated deep emotional conflict whose real origin was in the very early life adjustments.

The necessity for the careful check on organic and psysiological disturbance has been repeatedly underlined by the results of the findings. In about 25 cases thus far, important somatic disease previously unrecognized or, if recognized, incompletely treated, has been found. In this group of patients our use of laboratory facilities, consultant specialists and meticulous physical examinations have uncovered co-existing severe hypothyroidism, renal disease, allergies, osteomyelitis, Hodgkin's disease, atypical convulsive disorders, encephalopathy, and many other types of pathology, including gout.

The use of the same facilities to aid in the interpretation of new symptoms appearing in the course of treatment has allowed us to diagnose and treat acute sinusitis, parotitis, several types of dermatitis, Meniere's Syndrome, hypertrophic gastritis, hyperinsulinism, avitaminoses, trench mouth and flat feet.

The fact that the patient is discovered to have significant organic disease does not mean that he, therefore, does not have psychiatric illness also. As a matter of fact, somatic disease and its effects are inevitably woven into the pattern of his feelings. The relationship, therefore, between somatic and psychic disturbance is variable and frequently very complex.

As a single illustration of one kind of inter-relationship, I shall cite a patient who had been an aerial gunner in heavy bombardment aircraft, who was shot down and for a considerable period was a prisoner of war. In the course of these experiences his feet were quite severely frozen, he suffered a cerebral concussion of moderate degree, he developed severe widespread fungus disease of the skin, he developed moderately severe avitaminosis as a probable consequence of which he developed extensive gingivitis, pyorrhea and functional renal damage, as well as pes planus, one of the elements in the etiology of which was certainly prolonged malnutrition. He was, in short, for a period of months unable to stand, sit, lie down, eat or talk in any comfort and was not only in some pain every waking minute, but also had the reasonable fear that his body would never again be adequate to allow him to do all of the things which he wanted to do in work, play, marriage, and so on. In his case the usual psychic traumata associated with combat were relatively unimportant, and quite obviously, the

continued on next page



extreme anxiety and depression which he suffered could not be successfully treated as if it were in pure culture. It was necessary to treat, and treat successfully, his skin disease, his gums, his feet, and so on, in order for realistic therapy to be started. After about 20 therapeutic sessions over a period of six months, and the use of work in the occupational therapy shops for the gradual rebuilding of his confidence in his adequacy and integrity, this patient is now working full-time, and entering with enjoyment into his manifold former interests and activities.

At times the results of the psychic disturbances in themselves bring about significant somatic complications. Of this I shall cite the instance of a Navy veteran who developed relatively simple, but symptomatically severe, anxiety in an overwhelmingly threatening combat situation. His most troublesome symptom was the result of gastrointestinal dyskinesia, which had the effect of his voluntarily cutting down his food intake over a period of many months to the level of four or five cups of coffee and a bite or two of hamburger per day. The resulting vitamin deficiency alone progressively began to wear him down to the point of complete disablement, and the obvious treatment, accompanied by strong supportive psychotherapy coincident with his beginning to feel better, resulted in a very rapid and essentially complete cure. This man, also, is now conducting successfully a business of his own quite without symptoms.

The psychological section of the Service subserves two major functions. By the use of projective tests such as the Rorschach and Thematic Apperception Tests, and by differential scoring of the Wechsler-Bellevue, the psychologists have been able to give us many rapid and extremely valuable leads which allow us to make diagnostic and other decisions with greater rapidity and with greater confidence. In several cases, these test results have strongly indicated the presence of organic cortical damage and, also, of prepsychotic reactions before the clinical work-up recognized significant indications of such pathology. The psychology department, also, frequently subserves the very important function of vocational guidance testing and counselling, which is of particular usefulness in many of these young men where circumstances of the last few years have prevented the clarification of motives and drives toward a particular career or life work. Skilled, vocational counselling has aided several of our patients who formerly were unaware of the nature of their abilities and the directions in which their energies were most effectively used, to direct and clarify their motivations, so that from a practical point of view they have for the first time headed into work or schooling with decision and confidence.

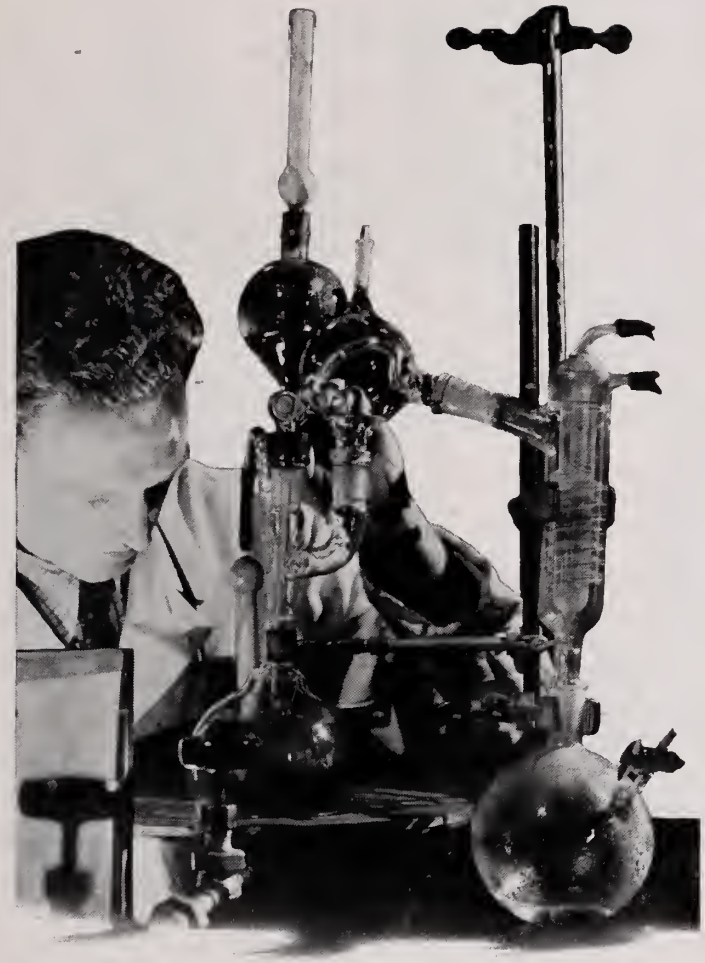
The social service section, similarly, has done crucially important work both on the investigative and the treatment side. In treatment, the worker has aided in restructuring unfortunate situational factors in the lives of patients, by the use of techniques which are now probably familiar to you.

In at least one instance, the carefully planned placement of a patient of very superior intellectual endowment in the research laboratories of one of the city's large industries, has resulted in a complete change in the patient's attitudes and ability to plan a productive future, and has, also, given the industry a most valuable employee.

I should like to speak now of what I term definite psychotherapy. This is a matter that has consistently been most difficult to define and to make understandable. In speaking of it, one runs into the road-blocks of conflicting psychiatric theories and the inordinately conflicting terms used by protagonists of the several theories. Still more basically, in an attempt to convey its nature, one runs into the further road-blocks inherent in explaining the interactions of any non-visible, non-palpable, non-measurable matters such as love, anger, desires, fears, loyalties and guilt feelings, which are from any pragmatic point of view immensely, and without question, "real". They are the matters which impel us to marry wives, practice medicine, form governments and police forces, go to church and go to war. Like energy (as the word is used as a specific term in physics and chemistry) which, similarly, is not palpable nor visible, these forces are known and can be evaluated only by their *effects*. One can evaluate them by their effects with considerable accuracy and even predictability.

Psychiatric disturbances are disturbances of these forces, these strong inner feelings, some of which are not recognized, or imperfectly recognized by the patient, or by you and me, when — and because — the feeling is painful or offensive to his particular standard of values and ethics, or to his particular sort of pride. These feelings, like affection, anger and fear are generated in the first place through a man's relationship with persons as he grows. These feelings find their expression (either clear-cut, happy and useful, or conflicting, violent and paralyzing) in relation to persons. The means, therefore, by which such feelings can be changed and directed is by working out his relationships with people. That is to say, in definitive psychotherapy. By using the development of the patient's relationships to a special person, the therapist, the feelings can be sorted out, made clear, and directed from confused, conflicting channels into useful directions. There are a number of ways in which this special relationship can be used to the patient's benefit. Our knowledge of how to use this kind of therapy is limited. There are patients whom the

continued on page 849





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psychotherapist cannot help. There are those for whom he can perform only a superficial function, in some cases as a partial safety valve and in some as a partial support. There are those, however, whom he can treat in a pretty fundamental way. It is, therefore, one of his first and most necessary functions to evaluate what it is possible for him to do for each person who comes to him and what it is not possible for him to do.

Although the types of treatment used vary widely and depend upon the type of psychopathology in each case, I will discuss only the most typical psychopathology seen, and the appropriate treatment used in this group of patients.

As I indicated before, the most typical pattern we have seen is a reactivation of old, unresolved strong feelings by specific traumatic circumstances. A somewhat over-simplified example of this is the case of a man who very early in his childhood and youth developed badly mixed feelings in relation to an undependable, inconsistent father. The boy developed strong, hostile, destructive feelings against the father which he could not allow himself to admit or recognize fully. As he grew up, the feelings found some expression in repeated over-hostile reactions against authoritarian or fatherlike figures such as teachers, employers, and the like. He released some hostility in this way, but was able to exert reasonable control over his actions toward such father figures, partly because the employers, regardless of their symbolic meaning to him, were in reality generally benevolent and dependable. At this stage then the man had strong, incompletely resolved feelings, but was not ill and was adjusting effectively to the realities of his environment. Upon getting into a combat situation he was led and commanded by an officer who was inimical and undependable, this time in a setting where these qualities constituted an active, immediate and overwhelming threat to the man. The man thereupon reacted, not only with an appropriate, reality-based fear of consequences, but had, in addition, all of his old, repressed hostility and bitterness released unmistakably in the direction of the father figure. The tremendous increase of anxiety, the feelings of guiltiness, the fear of his own aggressive impulses, and the desperate, defensive measures which his mind devised to get his aggressive feelings controlled, camouflaged and safely encapsulated, added up to make a severe and prolonged neurotic illness which, as far as I know, would not have been resolved by anything but definitive psychotherapy.

In the same general terms that I have been using, therapy in this case essentially consisted of assuming the role of a good, dependable, permissive, strongly supporting father figure, in whose presence the patient could aerate his aggressive feelings and receive objective understanding instead of overwhelming punishment, from whom he could get support and no longer feel alone and unprotected in the face of his fears, and with whom he could identify himself and work together in recognizing and disposing of the camouflages and defenses.

In this group of men the most frequent specific traumata that reactivates the old feelings are circumstances which have brought back feelings of guilt, feelings of hostility, feelings of loss of support from father-like and brother-like figures and feelings of loss of personal adequacy and integrity. There are various degrees of the depth of these and other feelings, (which may emerge from even more primitive levels of the personality). Again, with many exceptions, in general, the attempt is made to deal with them therapeutically at whatever level seems to contain the focus of the disturbance. Quite frequently intravenous administration of sodium pentothal in appropriate cases at appropriate times aids in the speed with which this work can be accomplished.

I will cite in more detail one quite typical instance of a disturbance parallel to the case I have been describing and the treatment which was used, apparently effectively. In this case the patient probably would not have continued treatment unless the use of pentothal had not first brought disturbing feelings so close to the surface that anxiety greatly increased for a time, and later provided great cathartic relief, followed by insight. In any event, it probably shortened treatment to one-tenth of the time it would otherwise have taken. Pentothal narcosis can be and is used as an office procedure after one has had considerable experience with it, and when used with discrimination, can reveal to both therapist and patient foci of disturbance which would otherwise take months to clarify, hidden as they are, by primary, secondary and tertiary defenses, in depth. Very seldom does pentothal accomplish magical, dramatic results, and even when it does, it does not, by any means, remove all the defenses.

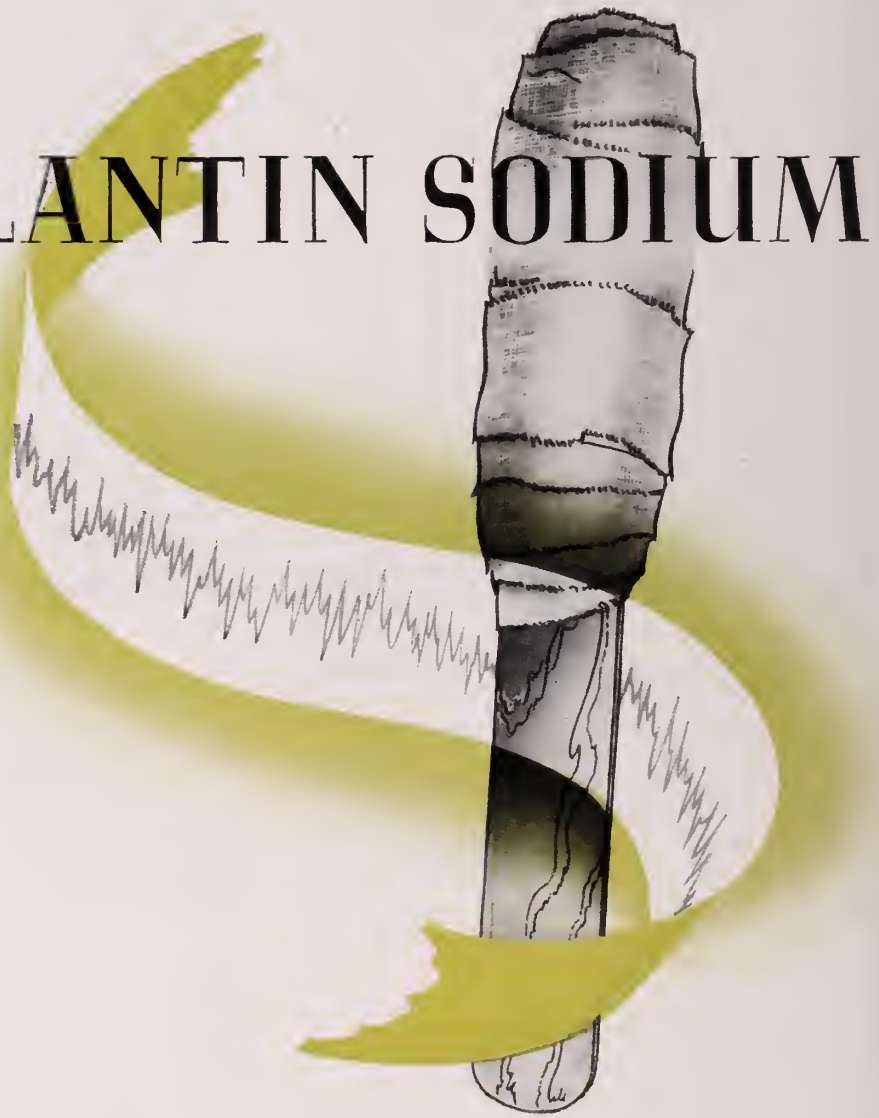
This patient was age 25 and unemployed at the time of referral. He made twenty-three visits over a seven-month period. Previous to Army service he was extremely out-going, active, competitive, social and had a consistently good work record.

Brought up from earliest infancy by a sister twenty years his senior, who was married but unable to have children of her own, he developed an unusually strong affection and identification with his sister-mother, and, as a small child, strong feelings of rejection by actual parents, anger against them, and guilt because of his hostility. He served as combat infantryman with ten months frontline

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DISTRICT MEDICAL SOCIETY MEETINGS

Kent County Medical Society Meeting

A regular meeting of the Kent County Medical Society was held September 12, 1946, at the Toll Gate Inn. The meeting was called to order at 5:10 p.m. by the President, Dr. Whitman Merrill. In the absence of the secretary, the Chair appointed Dr. Collom to serve as Secretary pro-tem.

The minutes of the previous meeting were read and approved.

The application for membership of Dr. Edmund T. Hackman was read and he was duly elected to membership.

A report was made by the treasurer concerning the expenses of the June meeting. It showed a balance over the collection made at the meeting. This deficit was ordered paid.

There being no other new business, a report of the Hospital Committee was requested.

Dr. George Young reported that a consultant had been engaged as authorized by the Society and that after an extensive survey he felt that a hospital in Kent County was not only desirable but actually a "must". His recommendation was that a 75 bed hospital be erected with surgical and service units designed for 150 beds to facilitate expansion when a need for additional beds became apparent.

The committee approached the firm of Will, Folsom & Smith who are currently conducting a campaign in behalf of the Rhode Island Hospital, with a request that they examine the feasibility of conducting a campaign in Kent County. After making a survey, Mr. Smith of that organization reported that his firm would be willing to conduct such a campaign beginning on or about March 1, for the purpose of raising $750,000. It was his opinion that such an amount could be raised in this district.

The committee has been assisted in its work by the advice of Dr. Arthur Ruggles on several occasions.

The committee feels that the next step toward organization of the hospital would be the appointment of the Board of Trustees. It has discussed many people residing in Kent County and has arrived at the following list of nominees: Chairman, Dr. Arthur Ruggles; Members, Messrs. Malcolm Brogdon, Murray, Alonzo Dodge, Albert Ruerat, Charles Algren, John C. B. Washburn, Albert Bradley, Frank Maury, Robert Champlin, Robert Quinn, Homer Gelineau.

It was moved by Dr. Collom and seconded by Dr. Tefft that the recommendations for Trustees made by the Hospital Committee, be approved and the Trustees appointed. The motion was carried.

The committee suggested that members of the Society be assessed to make up the difference between the assets of the Society and the cost of survey which amounted to $1,082.

It was moved by Dr. Tefft and seconded by Dr. Young that each member be assessed $20. to be applied to the consultant's fee. Motion was carried.

It was moved by Dr. Tefft and seconded by Dr. Young that the consultant's bill be paid. Motion carried.

The motion was made and carried that the meeting be adjourned.

Respectfully submitted,
Harold L. Collom, M.D.
Secretary pro-tem

* * * * *

A regular monthly meeting of the Kent County Medical Society was held October 10, 1946, at the Toll Gate in Westcott.

Dr. Merrill in the chair, it was voted that the reading of the minutes of the last meeting be dispensed with and the minutes as committed by Dr. Collom, Secretary pro-tem be approved.

The applications for membership of Dr. Ciro Scotti and of Dr. John C. Sarafian were submitted after approval by the Board of Censors. Both doctors were elected to membership.

A report from the Treasurer, Dr. Mack, was submitted with receipted bill for payment of the completed survey made by Dr. Craig.

Dr. Abbate moved "that the receipted bill be accepted and filed." It was so voted.

Dr. Merrill announced that Mr. Frank J. Morrissey of Coventry, Rhode Island, had accepted his appointment to the Board of Trustees.

Dr. Taggart representing the hospital committee said that a meeting has been held with the members of the Board of Trustees at which Dr. Ruggles had advised conservation.

continued on next page

The next meeting is scheduled for November 12 when Dr. Craig and Mr. Smith will be present. Dr. Tefft introduced the subject of "The American Association of Physicians and Surgeons," whose chief purpose is the education of physicians regarding socialized medicine.

Two members of the E. L. Patch Company showed a colored film on the treatment of Burns.

A vote of thanks was given these two men and their company for the interesting film.

Dr. Charles J. Hanson of Providence, Rhode Island, was then introduced to the assembly. He spoke on "Eye Conditions of Interest to the General Practitioner," stressing the importance of preschool visual examination and of visual conservation in general. The problem of eye disease as causal factor in creating systemic disturbances was of practical and timely interest.

A vote of thanks was rendered Dr. Hanson.

Dr. B. Tefft then made motion that the meeting be adjourned. It was so voted at 6:10 p.m. and dinner was served.

Respectfully submitted,

J. E. Vidal, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION MEETING

The regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. William Kalcounos at 8:45 p.m., Thursday, October 17, 1946, at the Pawtucket Golf Club.

The reading of the minutes of the previous meeting was dispensed with and the application for membership in the Association of Dr. Louis E. Hanna was read and referred to the Standing Committee. The applications of Dr. Henry Edward Turner and Dr. Bert Simmons Jeremiah were read as approved by the Standing Committee, and will be submitted to ballot at the next regular meeting.

A letter from the Executive Committee of the Staff of the Memorial Hospital in reply to the questions submitted by the Pawtucket Medical Association regarding medical education was read. It stated that this committee would be happy to discuss the questions submitted with a committee appointed from the medical staff of the Memorial Hospital rather than a committee from the Pawtucket Medical Association.

The meeting was then turned over to Dr. Robert T. Henry who had arranged the program. Dr. Henry introduced the speaker of the evening, Dr. William Lanigan of Medford, Massachusetts, former Commander, U.S.N., who gave an intriguing account of orthopedic problems encountered in the Pacific Theatre and presented a group of excellent lantern slides regarding amputations and compound fractures.

Supper was served and the meeting adjourned at 10:30 p.m.

The following members were present: Drs. Kalcounos, Mathewson, Beaudoin, Boucher, Masse, Ronne, McCaughey, Zolmian, Gordon, Doll, Stephen Kenney, Moor, Thomas Sheridan, Lovering, Woodcombe, Barry, Henry, Hennessey, Thompson, and Frank Hanley.

Respectfully submitted,

Kieran W. Hennessey, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 7, 1946.

The meeting was called to order by President Paul C. Cook at 8:37 p.m. With the consent of the members in attendance the President ruled that the reading of the minutes of the previous meeting would be omitted.

The President called for a report from the Committee on Entertainment. Dr. Herman P. Grossman, chairman of that committee, announced that the annual dinner of the Association would be held at the Wannamoisett Country Club on Wednesday,

continued on page 859

ANNUAL DINNER OF PMA

Approximately 125 members and their guests gathered at the Wannamoisett Country Club in East Providence on October 9 for the annual golf tournament and dinner of the Providence Medical Association. The affair was one of the most successful ever due largely to the splendid work of the Committee on Entertainment headed by Dr. Herman P. Grossman.

The President's trophy, awarded by Dr. Paul Cook, was won by Dr. Harry Darrah, while the low gross prize for members went to Dr. Frederic A. Webster. For the visitors Dr. Frank Hanley of the Pawtucket Medical Association claimed the low gross honors, and Mr. Charles Mason the low net trophy.

With Dr. N. A. Bolotow as master of ceremonies the evening program was highlighted by the award of golf and door prizes donated by pharmaceutical houses and other friends of members of the Association.

That the occasion was such a pleasant and enjoyable one for everyone was due to the efforts of Dr. Grossman's fine committee consisting of Drs. E. Wade Bishop, Ralph DiLeone, Carl D. Sawyer and Nathan A. Bolotow.

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DI-OVOCYLIN

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PROBLEMS AND PROCEDURES IN NEURO-PSYCHIATRIC OUT-PATIENT SERVICE

concluded from page 849

combat in Italy with every man in his platoon a casualty. He, himself, was wounded by sniper fire and evacuated because of wounds. A considerable portion of the muscles of the right thigh was destroyed and one testicle was shot off. He felt an appropriate amount of tension during combat, the present symptoms developing only after his hospitalization for wounds.

His presenting symptoms were nausea, gastric distress, extreme irritability, depression, complete inability to associate with people, enjoy former interests, or to work. No significant physical findings other than wound scars. No significant laboratory abnormalities. X-ray of the chest and G.I. series well within normal limits. Rorschach and TAT indicated average intelligence with functional impairment, including constriction, stereotype and lack of ability to establish normal relationship with people; feelings of anxiety and inadequacy were indicated. Anxiety apparently tied up with own sexual organs and battle experience. TAT content evidenced immaturity and great need for succorance.

Patient spent first few hours airing resentment and disgust at his previous treatment by doctors and their treatment of his sister who, at present, is suffering parallel symptoms.

With the aeration, aggressive feelings became translated more and more into increased tension and activity to the degree that he impulsively hit a man sitting behind him in a movie because of annoyance at this man's noisy shifting about in his seat. Following this the relationship of guilt feelings to hostility was discussed and intravenous sodium pentothal was begun. Under pentothal, without any suggestion by the therapist, tremendous abreaction of feelings of aggression and guilt took place. In first few pentothal interviews patient simply lived through traumatic experiences, particularly of his being wounded and of his feeling responsible for the death of a friend and his knifing German outposts in the dark; having amnesia and an inability to synthesize these matters on his emergence from the effects of the drug.

He developed at this point red spotty dermatitis of the hands and of the wrists. Allergy skin tests negative. After further acceptance of his feelings of guilt under pentothal three months after beginning of treatment in which he frequently used the phrase "their blood on my hands", red spots on hands cleared up and patient lost gastric symptoms, tension and fears, and began work. Insight increased with further pentothal interviews, and patient, himself, connected guilt feelings with castration fears, which he stated were appropriate punishment for his guilt in killing. By six months after beginning treatment patient was entirely asymptomatic for a period of a month at a time with very brief slip-backs into depression, capable of reversal by a single interview.

Patient is now engaged to be married, busy with all his old interests and working steadily.

I should like to cite further cases in detail, particularly several in which treatment was incompletely successful, or flatly failed. They would be instructive, and would present a more complete picture of the Service and its limitations. The subject of such failures, partial and complete, and the reasons therefore, is sufficiently important and relevant to deserve detailed study, which I hope to accomplish and present in the future.

MANAGEMENT OF THE CONVULSIVE CHILD

concluded from page 833

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[21]Bowen, M. Behavior problems in the hospital. Am. J. Nursing 39: 636 (June) 1939.



Similarly, there is a margin of safety, well beyond optimal needs of children, in *Vi-teens Homogenized Vitamins* (especially palatable in milk, water, juice or formula). Full size sample package for physicians upon request.

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Niacinamide	4 Milligrams



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PROVIDENCE MEDICAL ASSOCIATION

(continued from page 854

October 9, and that the annual golf tournament would be held at the Club in the afternoon. He briefly reported on the program he had planned for the day, and he urged the attendance of members.

The Secretary reported that the Executive Committee recommended the election to active membership of the following physicians: Drs. Joseph M. Badway, Stanley T. Grzebien, Hannibal Hamlin, Manuel Horwitz, Oscar Helmuth Hyer, Ernest K. Landsteiner, Raymond T. Stevens, Thomas R. Littleton, Richard J. Martin, Charles E. Millard, John Mochnacky, William S. Nerone, Arnold Porter, Vincent Zecchino. Dr. Samuel Clark moved that these physicians be elected to active membership in the Association. The motion was seconded and unanimously adopted.

The President announced that the week had been designated as national "Employ the Handicapped" week, and he stated that he had been requested to call to the attention of the membership the fact that the U. S. Unemployment Service is prepared to assist in the procuring of employment for physically handicapped persons.

The President announced that since the last meeting of the Association three members have died. He called for a moment of silence to the memory of Dr. James A. Gilbert, Dr. Dennett L. Richardson and Dr. Irving S. Cook.

Dr. Cook presented Dr. Eugene A. Field who gave a report of cases on "Congenital Anomalies of the Great Vessels." The importance of fluoroscoping the patient in various positions with the esophagus filled with Barium was emphasized in discussing the diagnosis of these, at times, obscure conditions. Slides were shown illustrating examples of a right sided aortic arch, with absence of the arch on the left. Also an example of a persistent right aortic arch, in addition to the arch normally present on the left side. This condition causes a constricting ring about the esophagus and trachea and may produce serious clinical symptoms. In addition, an instance of anomalous origin of the right subclavian artery arising from the left side of the aorta was illustrated as well as an example of a large anomalous left innominatevein, causing obstruction to the trachea and esophagus.

Dr. Cook introduced Dr. David G. Wright who presented a paper on "Present Procedures and Problems in a Neuro-Psychiatric Outpatient Service." He described, in interesting detail, the thoroughness with which problems of psychiatric illness are studied and treated. In attacking these problems, the functioning as a team of the psychiatrist, a clinical psychologist and a social worker was stressed. The magnitude of the work involved was suggested by the fact that a minimum of ten

continued on next page

An Announcement

To DOCTORS

Cooperating With

VETERANS ADMINISTRATION

Spencer Supports have been approved for purchase by the Veterans Administration through its Regional Offices, Hospitals, Homes and Centers. Purchases are authorized on the prescription of doctors cooperating with the Veterans Administration, including those who are treating veterans on an out-patient basis in their home communities.

In the treatment of veterans for conditions where support therapy is indicated, the doctor, as always, can rely on Spencers to meet his most exacting requirements.

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The reason Spencer Supports are so effective is this: Each Spencer Support is individually designed, cut and made after a description of the patient's body and posture has been recorded—and 15 or more measurements have been taken.

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concluded from preceding page

hours' labor is required for the basic investigative work of an average case. This method of approach was demonstrated to yield dividends, as a very significant number can conservatively be said to have completely recovered from a disabling mental illness. It was mentioned that in about 25 per cent of cases, significant somatic disease was concomitantly uncovered and treated. Pentothal narcosis and its occasional helpful use was illustrated.

The last paper of the evening was entitled "Neuro-Psychiatric Disorders — Office and Hospital Treatment" and was presented by Dr. Hugh E. Kiene. He stressed the advantages of early treatment, and discussed some features of the treatment of involutional melancholia, schizophrenia, etc. The role of electro-convulsive therapy in selective cases was illustrated. Psychotherapeutic aids were mentioned; the importance of a detailed program of daily and weekly activities; the use of Narco-synthesis in selected cases; and the value of modified insulin treatment in improving nutrition and well being in appropriate circumstances.

The meeting adjourned at 10:30 p.m.

Collation was served. Attendance was 78.

Respectfully submitted,

FRANK CUTTS, M.D., *Secretary*

"Hospitals which are interested in prepayment plans would do well to study most carefully not only the Blue Cross Hospitalization Plans but also the Medical Service Plans. It is realized in altogether too few instances that there is a fundamental difference between the contracts for hospitalization and the contracts for medical service. The contract for hospitalization is a multiple contract made between the subscriber and Group Hospitalization and between the hospital and Group Hospitalization, neither of which contracts directly affects the personal rights, obligations, privileges, and relationships of the individual. The contract between a patient and his physician, however, in a strict sense of the word is a contract between two individuals not so much for pay but for the intangibles which are implied in medical service. It is most important that the ethical relationships should be kept carefully separate one from the other and the hospital should not lightly enter into agreements with physicians or with paying agencies for medical, surgical, or obstetrical care."

Alphonse M. Schwitalla, S.J., President, American Catholic Hospital Association, in HOSPITAL PROGRESS, July, 1946, page 234.



to combat

depression characterized by

"chronic fatigue"

Depressed patients ". . . suffering from psychomotor inhibition complain of feeling tired, of not being able to get started on their daily tasks. and of an abnormal inclination to procrastinate. They make up their minds that they are going to do a certain thing but they never seem to get to it. Everything seems too big for them . . ."*

In the above quotation, Kamman emphasizes "chronic fatigue" as a dominant symptom in the type of depression most frequently encountered in daily practice.

Benzedrine Sulfate is particularly valuable in the presence of "chronic fatigue". It will, in most cases, help to overcome the depression and thus enable the patient to make a sincere and constructive effort to surmount his difficulties.

*Kamman, G. R.: Fatigue as a Symptom in Depressed Patients, Journal-Lancet 65:238 (July) 1945.

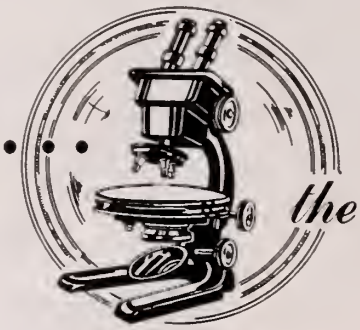
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Tablets and Elixir

benzedrine sulfate

(*racemic amphetamine sulfate, S.K.F.*)

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THROUGH . . .  *the Microscope*

Medical Service Plans

WHEN the California Physicians Service was formed in 1939 as a service corporation the insurance commissioner objected and contended that it was in reality an insurance company and subject to all the restrictive laws governing insurance. However, the California Medical Association and the California Physicians Service objected and held that, in their opinion, the rendering of medical care on a prepaid basis through a service corporation in which all doctors of medicine were free to participate was a professional matter, and not an insurance business. Accordingly, California Physicians Service commenced an action against the insurance commissioner for a declaratory judgment and the suit was started in 1940. This August the California Supreme Court ruled that the California Physicians Service is a service corporation and as such is not subject to the restrictive laws governing insurance companies and its operations are not under the supervision of the California insurance commissioner.

* * * * * * *

The current relationship between the average income of employed persons and the cost of living has created a problem for voluntary medical service plans. In New Jersey a practical approach to the problem has been evolved by Dr. Norman M. Scott, director of the Medical Surgical Plan for that state. Assuming that the dollar had a purchasing power of a hundred in 1941 when Medical Surgical plan contracts were framed, he asks: what should be the income levels if we are to meet the needs of the current "under average income" group? To assist in answering this question the Medical Surgical Plan in New Jersey turned to the Department of Agriculture for basic material in depicting the economic changes in the cost of living using as the base the assumption that the dollar was worth 100 cents in 1941. As the result of the studies the New Jersey group points out that if the employee and his wife enjoyed an income of $2,500 in 1941 they would require an income of $2,787 in 1942 and of $3,294 in June, 1946, to maintain their purchasing power. In view of the studies that have been made Dr. Scott points out that such variation in the relationship between average income and the cost of living leads to the thought that in fairness to our participating physicians and subscribers, the income limits applicable to our contract for any calendar year might be increased or decreased in the ratio of the New Jersey Consumers Price Index for the preceding or second preceding calendar year to such index for the year 1941. The entire problem including its implications is being studied by the board of trustees of the plan.

* * * * * * *

In this connection it is rather interesting to note that the medical service plan developed by the Medical Society of the District of Columbia states that the fees in the schedule shall be considered full compensation except where the individual subscriber has an income exceeding $2,500, or where the individual subscriber and his or her family have an income exceeding $4,500. In both instances the fees listed may not be considered as being full payment of the physician's services. The physician and the subscriber will agree on a charge for the services rendered and the fees listed will be applied on the physician's bill.

* * * * * * *

Other developments in the progress of medical care plans may be summarized as follows: In Minnesota the House of Delegates instructed its Committee on Organization of the Minnesota Medical Service to raise $100,000 to put the service into actual operation; the physicians in New Mexico have recently incorporated New Mexico Physicians Service, a non-profit corporation designed to furnish prepaid medical and surgical care in and out

continued on page 864

NO. 5 in Schenley Laboratories' continuing summary of penicillin therapy

FURUNCULOSIS: treatment with PENICILLIN SCHENLEY

The efficacy of penicillin in overcoming infections caused by the pyogenic cocci associated with furunculosis and carbuncles was established from the first clinical reports of the original Oxford investigators. Today penicillin is acknowledged to be the drug of choice in the treatment of pyogenic dermatoses.

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2. THE VALUE OF PENICILLIN OINTMENT SCHENLEY for topical application is quickly demonstrable where lesions are on the surface or readily accessible. Each gram of ointment contains 1,000 units of calcium penicillin incorporated in an anhydrous base.



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THROUGH THE MICROSCOPE

continued from page 862

of the hospital; after two years of work in studying medical care plans and their development the Louisiana Medical Society has incorporated the Louisiana Physicians Service and will operate a statewide voluntary prepayment surgical and obstetrical care plan in the near future: in the December issue of the Journal you will find an interesting report on medical care plans in New England, both those in operation and those proposed, as prepared by a committee of Rhode Island physicians serving as a subcommittee of the Council of the New England State Medical Societies in the discussion of this development of the extension of medical care.

Public Relations

In Pennsylvania the board of trustees recently voted $2,500 to employ Raymond Rich and Associates, of New York City, to make a survey of the Society's public relation needs and to review the current applicants for acceptance as public relations counsel to the state society. The Rich Association is the same organization which recently completed the study of the framework of the American Medical Association. Their report, which is to be submitted to the House of Delegates of the AMA at the special session in December, promises to be the highlight of the particular session.

* * * * * * *

Dr. Dwight H. Murray, chairman of the Committee on Public Policy and Legislation of the California Medical Association, recently suggested to the Council that it consider sending to England, and possibly to France or other European countries, a team composed of one physician and one economist. The purpose of such a trip would be to secure up-to-date information on the collection and disbursement of funds under state health insurance systems, the actual percentage of such funds which is eventually spent on direct medical care of beneficiaries, whether or not the people under such systems are actually receiving good medical care, whether or not the people are satisfied with the care they do receive, whether or not the physicians rendering the care are satisfied with the conditions under which they furnish service, and finally, whether or not the type of medical student now being attracted to the medical schools constitute the type of student which would normally be acceptable in this state and country.

* * * * * * *

Meanwhile, in Florida, the Board of Governors is busy carrying out the resolution adopted by the House of Delegates in June to establish a Public Relations Bureau. A complete and careful study of the problem has been made by the Board, and it looks forward to the immediate establishment of such a service for the medical profession of that state.

Medical Care for the Veterans

Medical societies throughout the country have been very eager and willing to sign contracts with the Veterans Administration to provide for the medical care of veterans. However, there appears to be a catch in the agreement that was overlooked by many of the societies, particularly those having large urban areas. The catch is that the veteran will not have free choice of a physician as generally understood because in all large areas where the Veterans Administration locally will set up, or has already set up, units providing medical service, the veteran will be referred there. It will only be where the Administration has not established dispensaries, clinics or units, by whatever name they may be called, that the veteran will be able to choose the physician in that locality to treat him for a service connected disability.

The situation in Rhode Island has yet to be settled. For example, with clinics planned in Providence, Woonsocket, Pawtucket, Newport, it would appear that the veteran will be directed to physicians in the employ of the Veterans Administration. In view of this situation the question has naturally arisen here as to what part the general practitioner will play in the general program, for it is apparent that the Medical Administrator of Veterans Affairs will probably only send out on referral to specialists whose services they have not employed on a full time or part time salary basis.

* * * * * * *

In Ohio where the contract was signed in July the situation was taken up with General Bradley when it became apparent to the general practitioners throughout the state that they were not going to see the veterans except for physical examination on a pension claim. The solution has yet to be reached, but apparently many states are going to find that the program does not promise all free choice of physician that was indicated in statements by General Hawley in public addresses before medical societies and in the agreements so carefully worded that are being signed by the various societies with the Veterans Administration.

* * * * * * *

A new note in the medical care for veterans was struck by the Arkansas Department of the American Legion when it passed a resolution in September urging that the government permit veterans who are now compelled to pay for treatments by chiropractors out of their own funds to receive the services both as regards out-patient treatment and hospitalization by chiropractors under the public laws. This probably may be taken as an indication of the type of activity that the medical profession

continued on page 866



30 days...
or life?

During baby's first critical 30 days, a lifetime may be gained or lost—good reason to minimize his burdens and leave him free from the gastrointestinal problems of excessive fermentation, upset digestion and diarrhea, and—good reason for 'Dexin' which has proved an excellent "first carbohydrate." Because of the high dextrin content it is not fermentable by the organisms usually present in the intestinal tract, and undergoes enzymic hydrolysis sufficiently slowly to permit absorption of dextrose about as fast as it is formed. No large quantities of fermentable carbohydrate are likely to be present in the intestine at any one time.

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THROUGH THE MICROSCOPE
continued from page 864

will be faced with in the next few years as veterans groups and others seek to blanket in osteopathic and chiropractic care on the basis of local demands by certain veterans or on the basis of support and agitation by the cultist groups.

Too Many Specialists

In a recent editorial "Minnesota Medicine," official publication of the Minnesota State Medical Society, points out that on March 1, 1946, there were 26,108 physicians who had been certified as specialists by the fifteen specialty and four subspecialty boards. Against this figure it points out that in 1939 some 4,000 had been certified. Thus, on an average, over 3,000 have been certified yearly since 1939 in spite of the war. The editorial further points out that at the beginning of the war there were only 5,256 approved residencies, whereas there are now 8,930, not including those in the army and navy hospitals and those in the Veterans Administration. In view of these facts "Minnesota Medicine" draws a conclusion that we are headed in the near future for an over production of specialists, for it estimates that 85 per cent of ills can be well taken care of by general practitioners, and if this is so, the percentage of specialists should not be more than 15 per cent of practicing physicians.

While heartily approving of the certification of specialists by specialty boards, the editors point out that for the good of medical practice in general every encouragement should be given recent graduates to enter general practice and no discouragement such as discrimination against them by hospitals should be tolerated.

Physicians Honored

Within the same week in September unusual tributes came to two physicians who reside a thousand miles apart.

On September 5 the Fulton County Medical Society of Georgia in regular meeting paid honor to Dr. Thomas Dick Longino. On September 7 Dr. Longino attained the venerable age of 100 years. When he was born anesthesia was only 4 years old, while antiseptic surgery was not announced to the world for 21 years, in 1867, although it was a long time after that before Lister's discovery became universally adopted. During the lifetime of this physician this country has engaged in five wars. In accepting the solicitations for his enviable record of service to humanity Dr. Longino attributed his long life to altruism.

* * * * * * *

On September 10 the town of Madison, Connecticut, closed its stores and its schools and turned

continued on page 868

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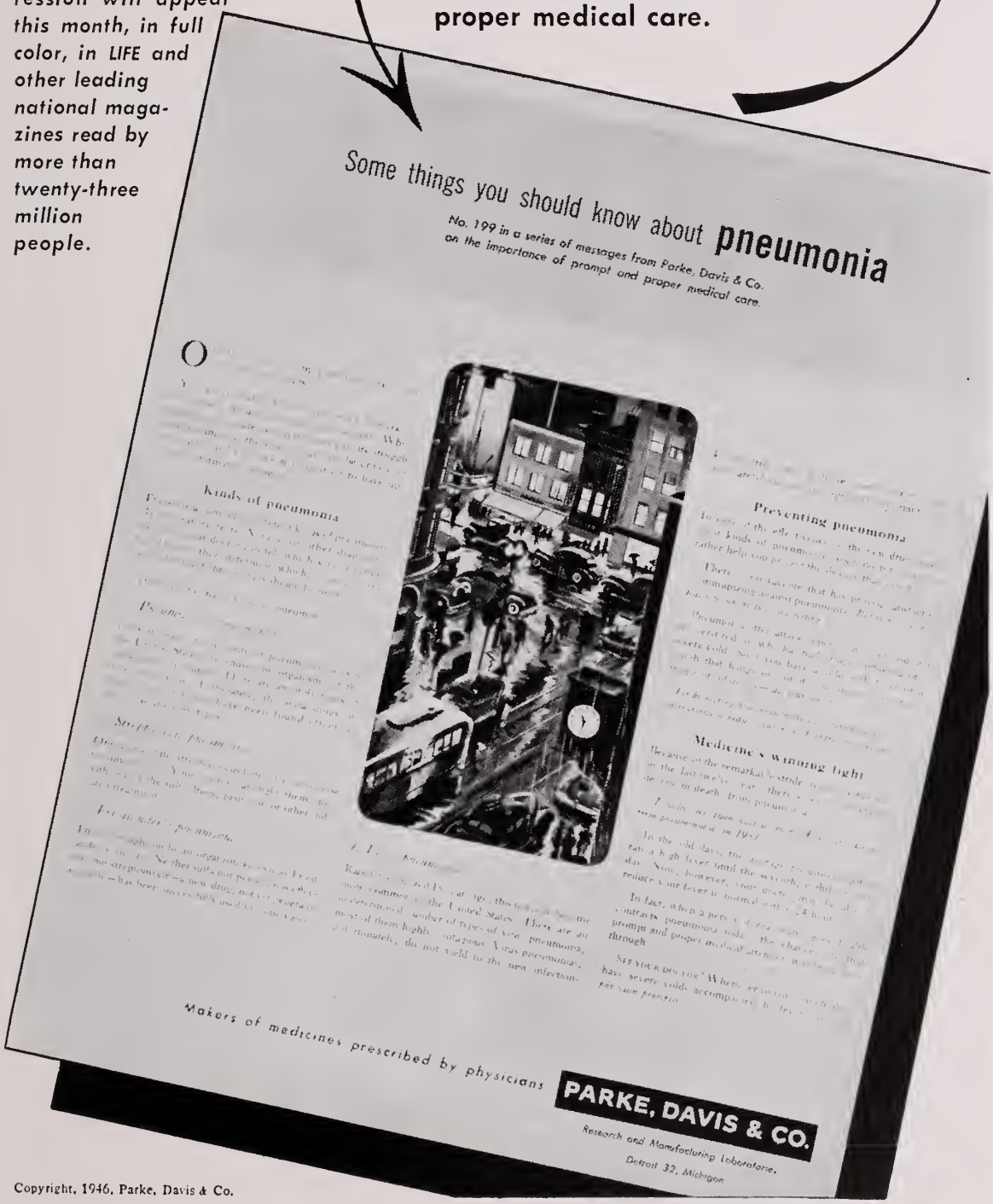
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"See Your Doctor"

This is the 199th advertisement in the Parke-Davis series on the importance of prompt and proper medical care.



Copyright, 1946, Parke, Davis & Co.

THROUGH THE MICROSCOPE

continued from page 866

out in force to honor its most distinguished citizen, Dr. Milo P. Rindge. For almost 40 out of his 74 years Dr. Rindge has labored in the health interests of the people of Madison and the neighboring communities as town health officer, family physician and friend. The celebration in his honor consisted of a public reception and a testimonial dinner which was attended by all the leading people of the town, and at which the citizens of the community presented him with a handsome pocket watch in appreciation of his forty years of faithful service to the community.

Maine Appoints Executive Secretary

Maine became the fifth New England State to appoint an executive secretary on a full-time basis. The position was approved by the Association at its meeting at Poland Springs in June when the annual assessment was raised to $35.00 for active members to provide for the creation of a central office with an executive officer in charge. Appointed as the executive secretary was Mr. W. Mayo Tayson, of Portland, who has been a member of the Maine Legislature for 5 consecutive two-year terms. He has been a practicing attorney in Portland for 16 years.

Medical Facts

With John L. Lewis again threatening a coal strike for the nation, we note with interest that the survey of health and medical aspects of the mining situation is going forward progressively in Eastern Kentucky and West Virginia under the supervision of Admiral Joel T. Boone, of the Navy Medical Corps. This survey has for its purpose the determination of the character and scope of improvements which should be made to provide the mine workers of the nation with medical, housing, and sanitary facilities conforming to recognized American standards.

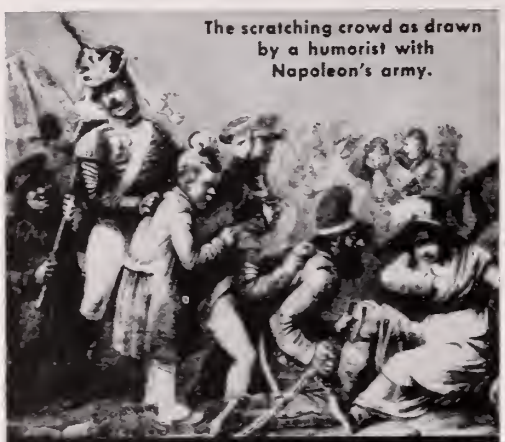
* * * * * * *

For some time the Connecticut State Medical Society has been receiving contributions for its building fund, and within the immediate future the board of trustees will indicate a personal solicitation campaign among all the members for donations. The site for the new home of the Society has already been purchased, and at the present time architects' drawings of the proposed building and tentative floor plans are being drafted.

* * * * * * *

In Texas, the Dallas Academy of Medicine recently established a new health museum whereby it is hoped to make health "visible, audible, and intelligible" to the general public. Another immediate project of the Dallas Academy is the erection of a half-million dollar building adjacent to the South

continued on page 872



Benylate
BREON

is supplied in 4 oz., pint and gallon bottles.



George A. Breon & Company
KANSAS CITY 10, MO NEW YORK ATLANTA LOS ANGELES SEATTLE

ITCH in 1800

was treated medically by applying a mixture of lard and gunpowder.

The 1946 treatment is

BENYLATE-BREON

One application usually eradicates scabies as well as head lice and body lice.

Benylate is a lotion of benzyl benzoate 25% in triethanolamine stearate. White, cleanly, greaseless, it requires no dilution but is ready to apply for quick relief from itching; it penetrates skin crevices with lethal effect on mites.

Benylate is the trademark of



SOME ADVANTAGES of Campbell's STRAINED BABY SOUPS

Q. The edible solids of the meats are retained. Why?

A. While the juices of meats contain valuable nutriments, the fibrous parts contain even more. In the preparation of Campbell's Strained Baby Soups the meats are prepared so that *all* of the edible solids as well as all the meat juices are retained to aid baby's growth and well-being.

Q. The utmost precaution is used to retain natural flavors. Why?

A. Every mother wants her baby's food to be palatable. Campbell's preparation and cooking methods have been devised to retain natural flavors as far as possible. Babies develop preferences early, accept some foods, reject others. Their acceptance of Campbell's Strained Baby Soups is indicated by the increasing demand for these soups wherever they have been introduced.

Q. All the Vegetables get special handling. Why?

A. Unless vegetables are prepared with the greatest of care and skill, they are likely to lose a large proportion of their valuable vitamins. Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins.

A comprehensive analysis of each soup may be had upon application to Campbell Soup Company, Camden, New Jersey.

5 KINDS:

CHICKEN
BEEF
LAMB
LIVER
VEGETABLE

All in Glass Jars



Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . *and in good flavor.* Every resource of Campbell's Kitchens is devoted to that aim.



LOOK FOR THE RED-AND-WHITE LABEL



▪ ▪ ▪ during Convalescence . . . in Dysmenorrhea . . . following Childbirth . . . at the onset of the Menopause . . . following Bereavement or Misfortune . . . in Old Age . . .

. . . *Dexedrine* may be relied upon to increase the patient's accessibility to treatment; to effect a remarkable improvement in mood and outlook; and to aid in restoring a normal grip on life and living.

Dexedrine Sulfate tablets
(dextro-amphetamine sulfate)

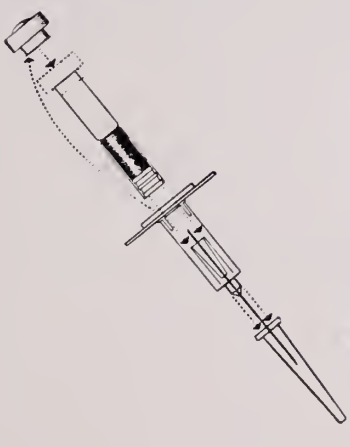
Smith, Kline & French Laboratories, *Philadelphia*

As easy as . . . . . .



Perhaps not quite . . . but you will find it almost as simple as that to prepare for an injection of Abbott's Romansky formula of penicillin calcium in oil and wax when you use a new B-D* Disposable Cartridge Syringe. No further sterilization of syringe and needle, no drying, and no danger of complications from traces of water. No difficulty of drawing the heavy suspension from a bulk container and no wasted medicament. And, furthermore, no bothersome cleaning of needle and syringe afterwards. *Just throw them away.* Each set consists of a disposable plastic syringe with an affixed standard 20-gauge, 1½-inch stainless steel needle and a glass cartridge-plunger containing a 1-cc. dose of 300,000 units of penicillin suspended in peanut oil and beeswax. It is complete, compact, easy to carry and ready for immediate use. Always a new, sharp needle and an accurate dose. Supply sometimes doesn't meet the heavy demand, but we're making more sets every day.
ABBOTT LABORATORIES, North Chicago, Illinois

*T. M. Reg. Becton, Dickinson & Co.



Abbott's Penicillin in Oil and Wax
(ROMANSKY FORMULA)
with the B-D disposable cartridge syringe

CARE OF POST-OPERATIVE, CARDIAC AND ELDERLY PATIENTS

Bayview Convalescent Home

ELIZABETH A. SANTOS

57 Stokes St. Conimicut, Rhode Island

BAYVIEW 1092-R

Strand Optical Co.

PRESCRIPTION OPTICIANS

307 STRAND BLDG.
77 WASHINGTON ST.
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GASPEE 4696

Curran & Burton, Inc.

GENERAL MOTORS
HEATING EQUIPMENT

COAL OIL

TURKS HEAD BUILDING, PROVIDENCE

GAspee 8123

FOR SALE

Majestic Portable

ELECTRO - SURGICAL UNIT

Diagnostic Current — Cystoscopic Attachment
BRAND NEW

Telephone: GAspee 6637

THROUGH THE MICROSCOPE

continued from page 868

western Medical Foundation which will contain the offices of the various health organizations which are members of the Academy, a medical library, an auditorium, and several small meeting rooms.

* * * * * * *

Recently a reporter of the INDIANAPOLIS STAR wrote a series of articles concerning the Kaadt Clinic located in South Whitley, Indiana. The purpose of the exposé was to show that the clinic's treatment, so called, for diabetics has very little if any scientific or therapeutic value. The interesting point in the Editorial comment in the *Indiana State Medical Journal* which has been in our mind for some time is the following statement: "Just where people get the notion that one of the jobs of being a doctor is to serve as health police is beyond us. Our notion is that it is the duty of the state to look after health affairs; the medical profession always has stood ready to render every possible assistance, but it certainly is not our job to do the police work and the prosecution."

* * * * * * *

Of the three million dollars appropriated under the Hill-Burton Act for hospital survey and planning, only $15,989 is allocated to Rhode Island, and of the $75,000,000 for construction only $280,275 is permitted for this state. Apparently there will be little hospital construction other than that by voluntary contributions to offer existing institutions in Rhode Island.

Meanwhile, a recent survey conducted in Michigan indicates that fewer and bigger hospitals will provide better, as well as more economical, medical care for Michigan. In the Detroit region, for example, the plan calls for construction of five new hospitals in rapidly expanding suburban areas and consolidation of the seventy-one existing hospitals into twenty-nine units.

* * * * * * *

HERE AND THERE: New methods of attack on gastric cancer will be outlined at a conference scheduled to be held December 5 and 6 at the Billings Hospital, University of Chicago, according to a recent announcement by Dr. Thomas Parran, Surgeon General of the United States Public Health Service * * * * * * On October 4, the American Legion unanimously adopted a resolution opposing compulsory health insurance at its annual session in California. As a result of this action opposition to compulsory health insurance now has the full resources of the largest and most influential group among the 15 million American veterans * * * * * * Twenty-six states and Hawaii have agreed to match funds with the federal government

continued on page 874

WHEN NEW ENGLAND WAS YOUNGER



In the 1890's...

H. P. Hood & Sons again pioneered for an improved milk supply by paying dairy farmers a premium for higher quality milk. Hood's was the first dairy company in New England to take this important step in the control of "on-the-farm" quality.

TODAY...

you get the benefit of Hood's 100 years of pioneering for extra quality in dairy products. Extra precautions at the dairy farm, extra safeguards in shipping, in laboratory control, extra protection all the way from farm to your home are yours when you buy Hood's. *You* like *Hood's* products better—because they *are* better!

HOOD'S

MILK • ICE CREAM

H P HOOD & SONS DAIRY PRODUCTS

ONE HUNORED YEARS' EXPERIENCE TO HELP US SERVE YOU BETTER

1846 — *Celebrating our 100th Anniversary* — **1946**

THROUGH THE MICROSCOPE

concluded from page 872

to provide lunches for millions of needy school children according to an announcement made recently following a survey by the Council of State Governments. The Federal Government in years past financed a school lunch program without state aid * * * * * * The $34,000 prize contest for the physicians' art contest on the subject of "Courage and Devotion Beyond the Call of Duty" will be judged at the Atlantic City Centennial Session of the AMA to be held from June 9-13 * * * * * * At the annual meeting of the American College of Chest Physicians held at San Francisco this past summer Dr. U. E. Zambarano, Superintendent of the State Sanatorium at Wallum Lake, was re-elected governor of the college for the state of Rhode Island * * * * * * An appeal to enlighten citizens to refrain from supporting antivivisection activities was issued by the American Diabetes Association when it held its meeting in Toronto celebrating the silver anniversary of the discovery of insulin which was due in great measure to the research by Drs. Banting and Best on experimental work with dogs * * * * * * The semi-annual meeting of the House of Delegates of the American Medical Association will be held at Chicago from December 9 to the 13. On the previous weekend the Secretaries of the state medical societies and the Editors of the state medical journals will hold their annual conferences to discuss mutual problems.

Patronize Journal Advertisers

SCIENTIFIC EXHIBIT

Centennial Session — American Medical Association

At the Centennial Session of the American Medical Association to be held in Atlantic City, June 9 to 13, 1947, the Scientific Exhibit will include both the history of medicine during the past Century and the latest developments of medical science.

Application blanks for space are now available. All applicants must fill out the regular form. Applications close on January 13, 1947, after which time the Committee on Scientific Exhibit will make its decision and notify the applicants.

Application blanks for space should be procured as soon as possible. They are available from The Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

E. P. ANTHONY, INC.

Druggists

178 ANGELL STREET

PROVIDENCE, R. I.



Medical Secretaries

Edgewood Medical Secretaries are skilled in laboratory technique, medical stenography and accounting. Interested professional men should phone or write the Placement Office.

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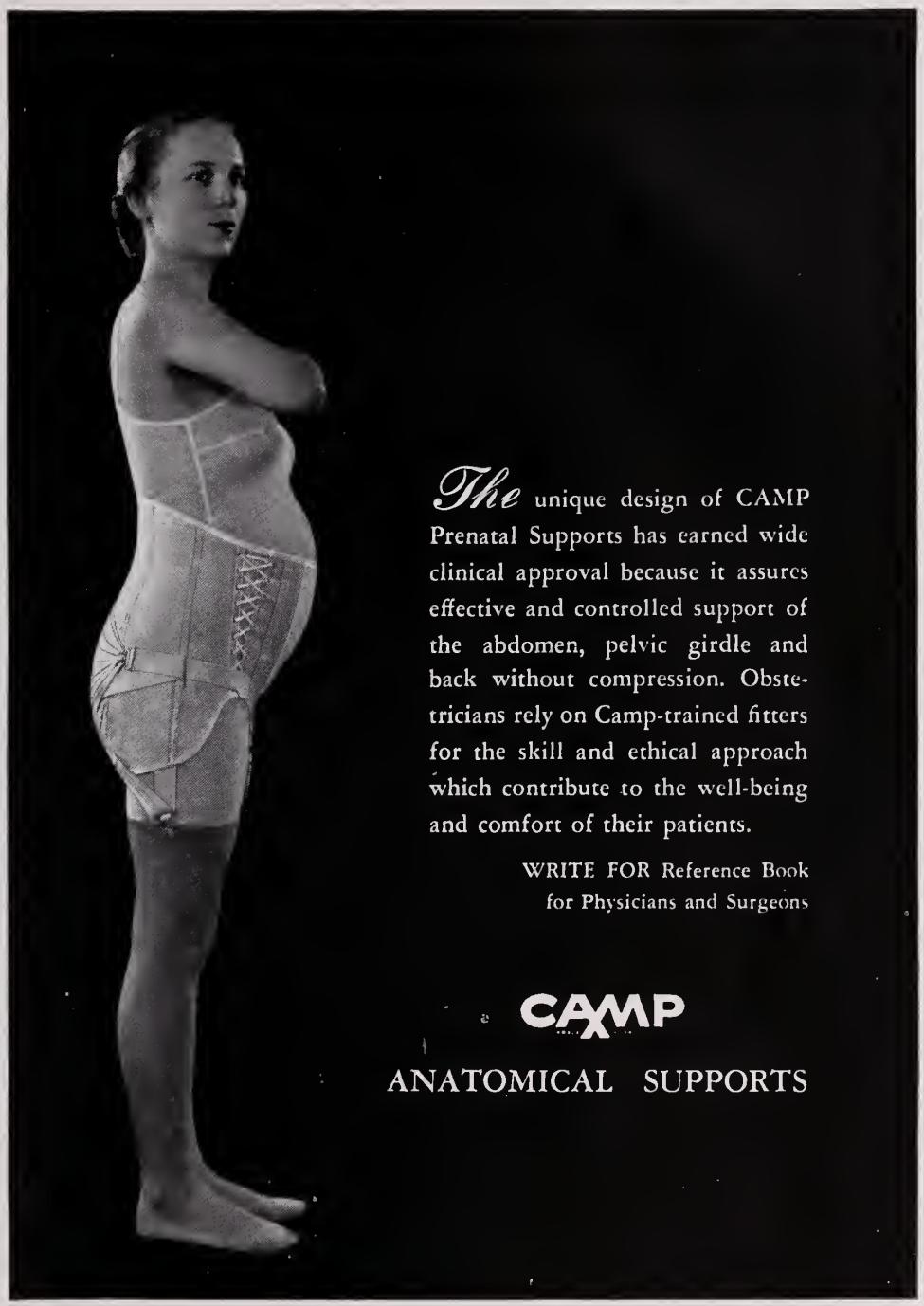
ROUGH HANDS

FROM TOO MUCH SCRUBBING?

Soften dry skin with AR-EX CHAP CREAM! Contains carbonyl diamide, shown in hospitol test to make skin softer, smoother, and even whiter! *Archives of Derm. and S., July, 1943.* FREE SAMPLE.

AR-EX CHAP CREAM

AR-EX COSMETICS, INC., 1036 W. VAN BUREN ST., CHICAGO 7, ILL.



S. H. CAMP AND COMPANY • Jackson, Michigan

World's Largest Manufacturers of Scientific Supports

Offices in New York • Chicago • Windsor, Ontario • London, England

It's prescribed

Rhinitis . . .

Sinusitis . . .

Nasopharyngitis . . .

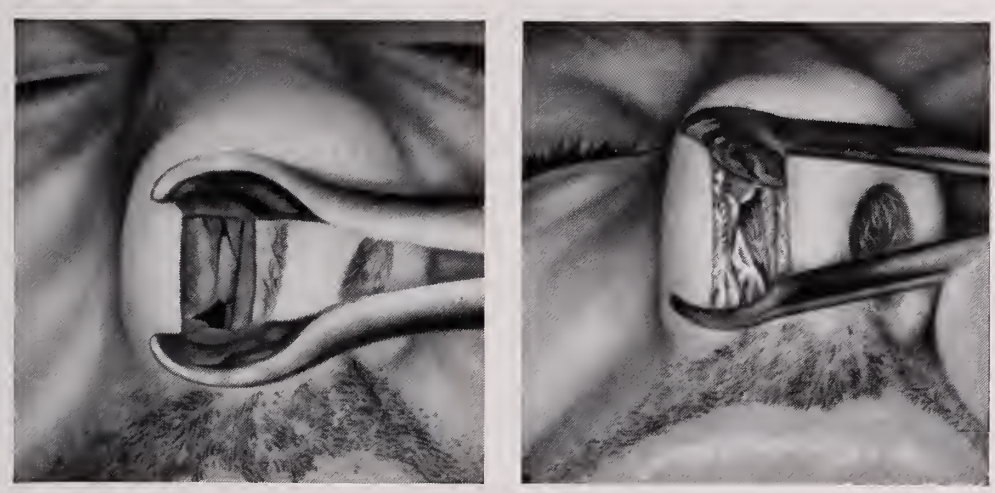
Pharyngitis . . .

Paredrine-Sulfathiazole Suspension

Vasoconstriction in minutes

. . . Bacteriostasis for hours

because it works . . .



(*Left*) **Before administration of Paredrine-Sulfathiazole Suspension:** Turbinates acutely inflamed, highly engorged, and in contact with septum. Air passage completely blocked.

(*Right*) **30 minutes after instillation of Paredrine-Sulfathiazole Suspension:** Turbinates constricted; ventilation and drainage promoted. Infected areas rendered accessible to the sulfathiazole, which is lightly frosting inferior and middle turbinates.

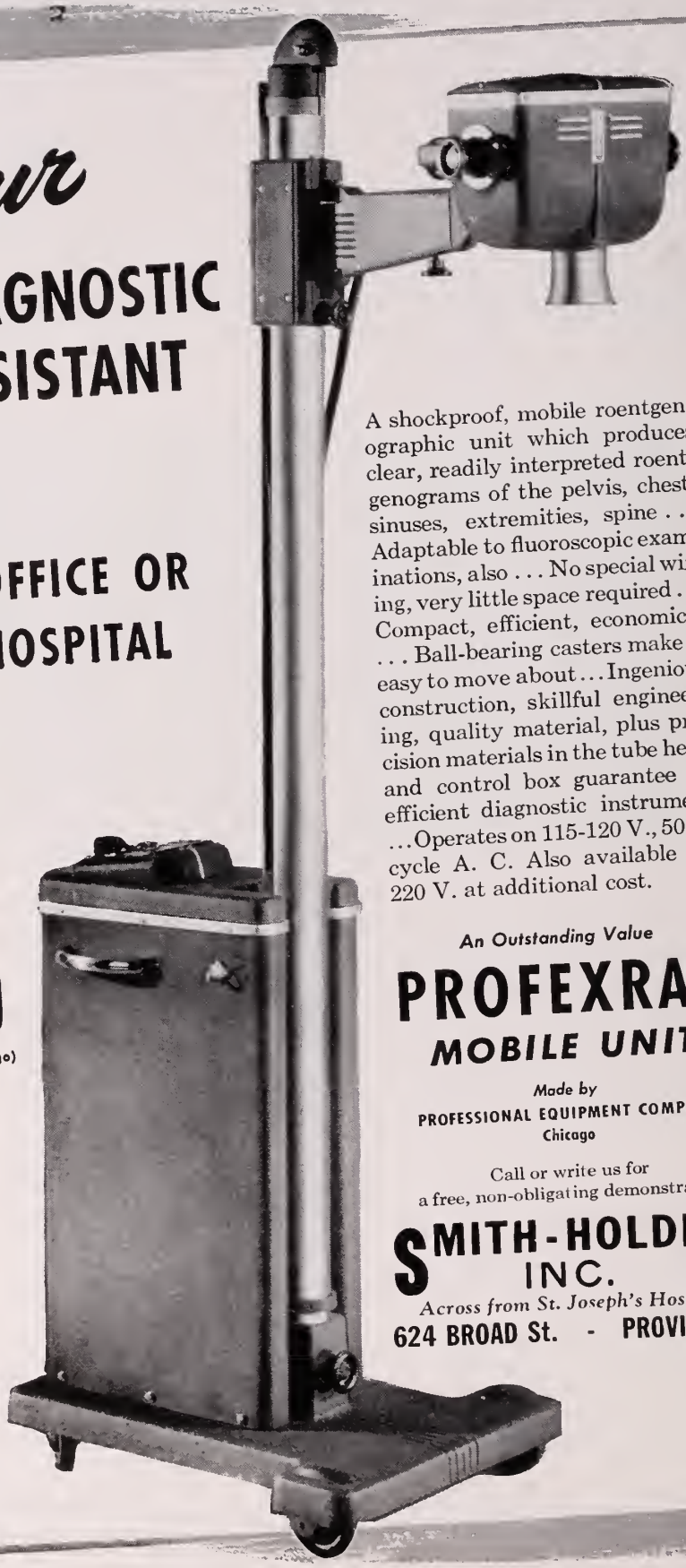
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DIAGNOSTIC ASSISTANT

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OFFICE OR HOSPITAL



A shockproof, mobile roentgenographic unit which produces clear, readily interpreted roentgenograms of the pelvis, chest, sinuses, extremities, spine . . . Adaptable to fluoroscopic examinations, also . . . No special wiring, very little space required . . . Compact, efficient, economical . . . Ball-bearing casters make it easy to move about . . . Ingenious construction, skillful engineering, quality material, plus precision materials in the tube head and control box guarantee an efficient diagnostic instrument . . . Operates on 115-120 V., 50-60 cycle A. C. Also available for 220 V. at additional cost.

$650

(F.O.B. Chicago)
Terms may be arranged

An Outstanding Value

PROFEXRAY

MOBILE UNIT

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PROFESSIONAL EQUIPMENT COMPANY
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Call or write us for
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SMITH-HOLDEN INC.

Across from St. Joseph's Hospital
624 BROAD St. - PROVIDENCE

Toward Faster Ultimate Recovery

IN HYPOCHROMIC ANEMIA



ADMINISTRATION of *all* the factors known to aid restoration of the hemoglobin level may be expected to produce more rapid hematopoiesis when excessive blood loss, blood destruction, or increased demand upon blood-forming organs results in secondary anemia.

Livitamin presents specific principles for treatment or prevention of hypochromic anemia: iron for the synthesis of hemoglobin, the erythrocyte-maturing factor supplied by liver extract, and B vitamins for correction of the usually present deficiency and for better iron utilization.

Supplied in a palatable, easily administered liquid form, Livitamin is indicated not only in secondary anemia, but also prophylactically during pregnancy and lactation, in preparation for elective surgery, and to hasten recovery after infection, prolonged illness, or surgery.



Each fluidounce of Livitamin presents:

Fresh Liver (as Liver Concentrate)	2 oz.
Thiamine Hydrochloride (B_1)	3 mg.
Riboflavin (B_2, G)	1 mg.
Nicotinamide (Niacinamide)	25 mg.
Pyridoxine Hydrochloride (B_6)	1 mg.
Pantothenic Acid	5 mg.
Iron and Manganese Peptonized	30 gr.

Contains the vitamin-B-complex factors naturally occurring in liver and rice bran, fortified with synthetic B_1, niacinamide, B_2, B_6, pantothenic acid and with iron and manganese.

THE S. E. MASSENGILL COMPANY
Bristol, Tenn.-Va.

LIVITAMIN

NEW YORK • SAN FRANCISCO • KANSAS CITY

SE Mass Co

LACTOGEN + WATER = FORMULA

1 LEVEL TABLESPOON — 2 OUNCES — 2 FLUID OUNCES

40 CALORIES (APPROX.) — 20 CALORIES PER OZ. (APPROX.)



Successful in Infant Nutrition



DEXTROGEN + WATER = FORMULA

1 FLUID OUNCE — 1½ OUNCES — 2½ FLUID OUNCES

50 CALORIES — 20 CALORIES PER OUNCE

No advertising or feeding directions, except to physicians. For feeding directions and prescription pads, send your professional blank to

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a switch in time

A SWITCH to 'Wellcome' Globin Insulin with Zinc can often save the annoyance of a second or third daily insulin injection—for in many cases the patient's needs can be supplied with *only one injection a day* of this unique intermediate-acting insulin. Three distinct steps provide the welcomed change-over:

1. THE INITIAL CHANGE-OVER DOSAGE: The first day, 30 minutes or more before breakfast, give a single dose of Globin Insulin, equal to ½ the total previous daily dose of protamine zinc insulin or of protamine zinc insulin combined with regular insulin. The next day, dose may be increased to ⅔ former total.

2. ADJUSTMENT TO 24-HOUR CONTROL: Gradually adjust the Globin Insulin dosage to provide 24-hour control as evidenced by a fasting blood sugar level of less than 150 mgm. or sugar-free urine in the fasting sample.

3. ADJUSTMENT OF DIET: Simultaneously adjust carbohydrate distribution of diet to balance insulin activity; initially 2/10, 4/10 and 4/10. Any midafternoon hypoglycemia may usually be offset by 10 to 20 grams carbohydrate at 3 to 4 p.m. Base final carbohydrate adjustment on fractional urinalyses.

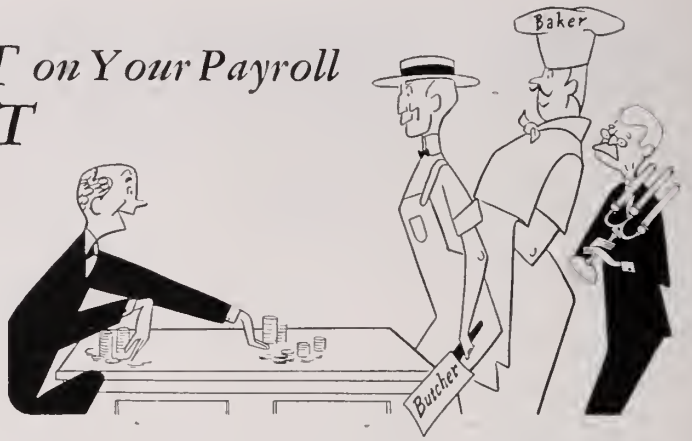
Most mild and many moderately severe cases may be controlled by *one daily injection of 'Wellcome' Globin Insulin with Zinc.* Vials of 10 cc.; 40 and 80 units per cc. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Pat. 2.161,198. Literature on request.

'Wellcome' Trademark Registered

'WELLCOME' Globin Insulin WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

Put Yourself **FIRST** *on Your Payroll instead of* **LAST**



How to Have Income for the Rest of Your Life

When you sit down to take care of your monthly bills, the butcher, the baker, the candlestick maker, each gets what's coming to him — but are you equally careful about setting aside something for yourself and your family?

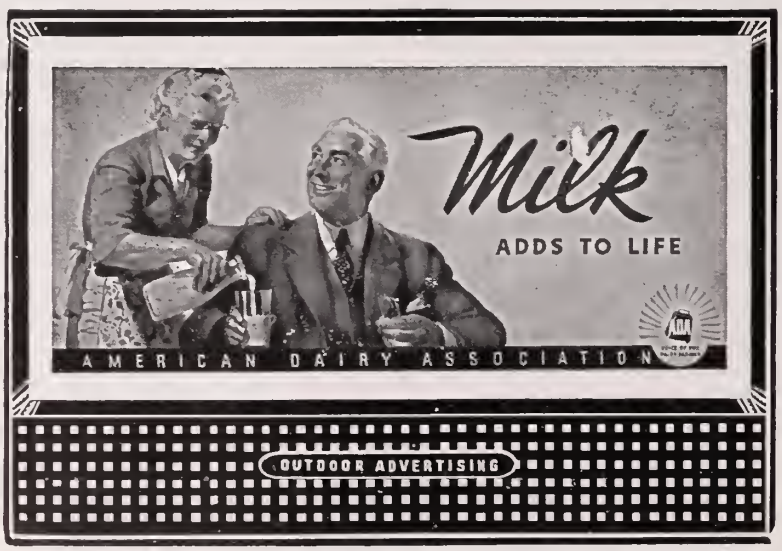
Too many of us devote our income to meeting present and past expenses, and save only if there's something left over.

But why put yourself last on the list? Make a definite program for the future a regular part of your budget.

Read about The Connecticut Mutual's Retirement Income plan which enables you to enjoy real peace of mind. Let us send you a copy of our booklet, "What Is the Retirement Income Plan?"

The Connecticut Mutual Life Insurance Company
Walter K. R. Holm, Jr., *General Agent and Associates*
Suite 1814, Industrial Trust Building, Providence 3, Rhode Island

THIS BILLBOARD . . . like CERTIFIED MILK



speaks to those persons of middle life and beyond.

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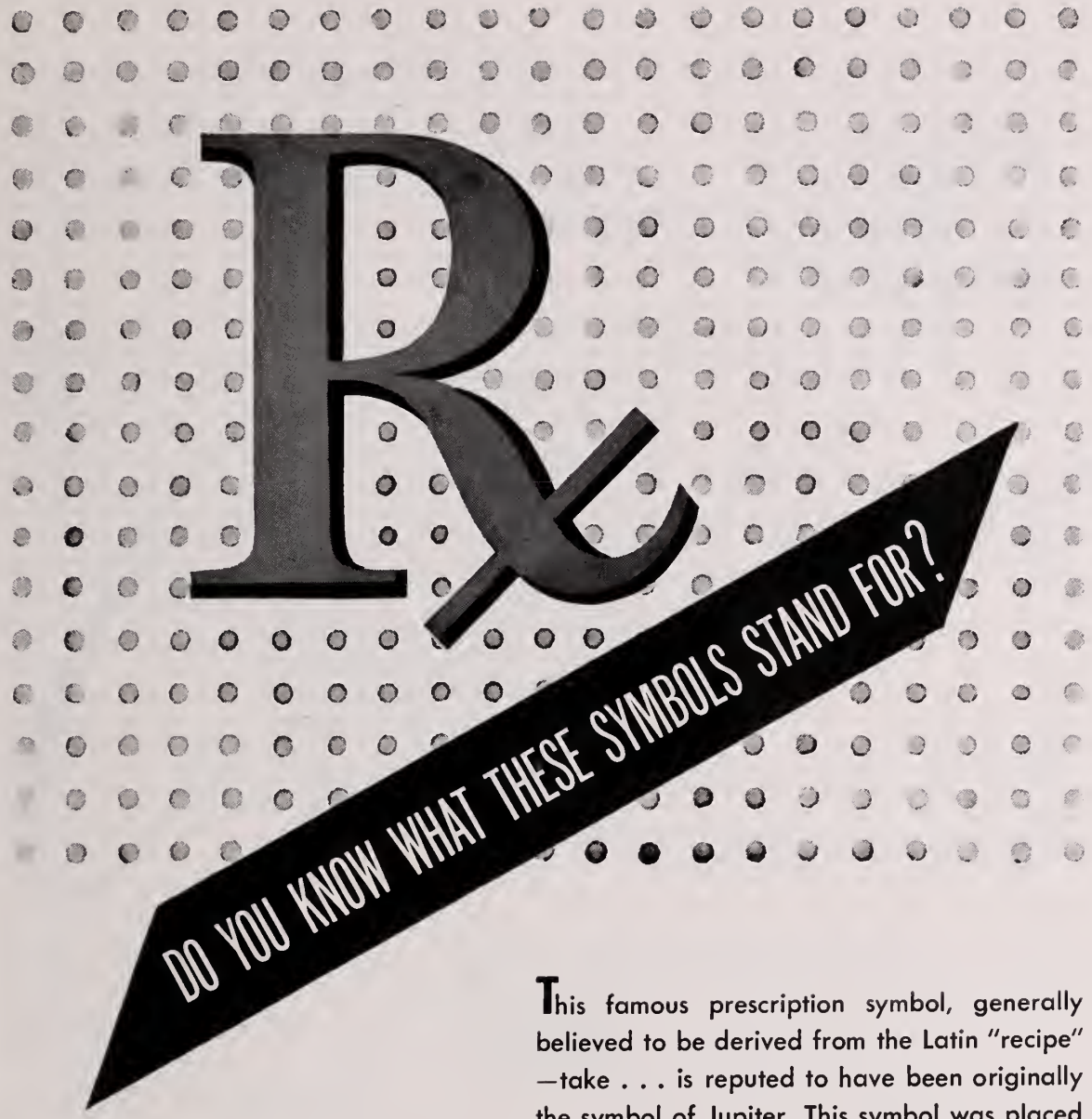
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H. P. Hood Co.	DE 3024
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This famous prescription symbol, generally believed to be derived from the Latin "recipe" —take . . . is reputed to have been originally the symbol of Jupiter. This symbol was placed at the top of a formula to propitiate the king of gods in order that the compound might act favorably.

Almost as famous, but rooted purely in science, is the 43-year-old Rexall symbol of dependable drug service—displayed in selected and conveniently located pharmacies throughout the nation. It is a sign that fine Rexall drugs and expert pharmacy are at your service.

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DRUGS

REXALL FOR RELIABILITY

UNITED-REXALL DRUG CO.
LOS ANGELES, CALIFORNIA

PHARMACEUTICAL CHEMISTS FOR MORE THAN 43 YEARS

Eye-witness Reports...

IT is one thing to *read* results in a published research. Quite another to see them with your own eyes.

PUBLISHED STUDIES* SHOWED WHEN SMOKERS CHANGED TO PHILIP MORRIS SUBSTANTIALLY EVERY CASE OF THROAT IRRITATION DUE TO SMOKING CLEARED COMPLETELY, OR DEFINITELY IMPROVED.

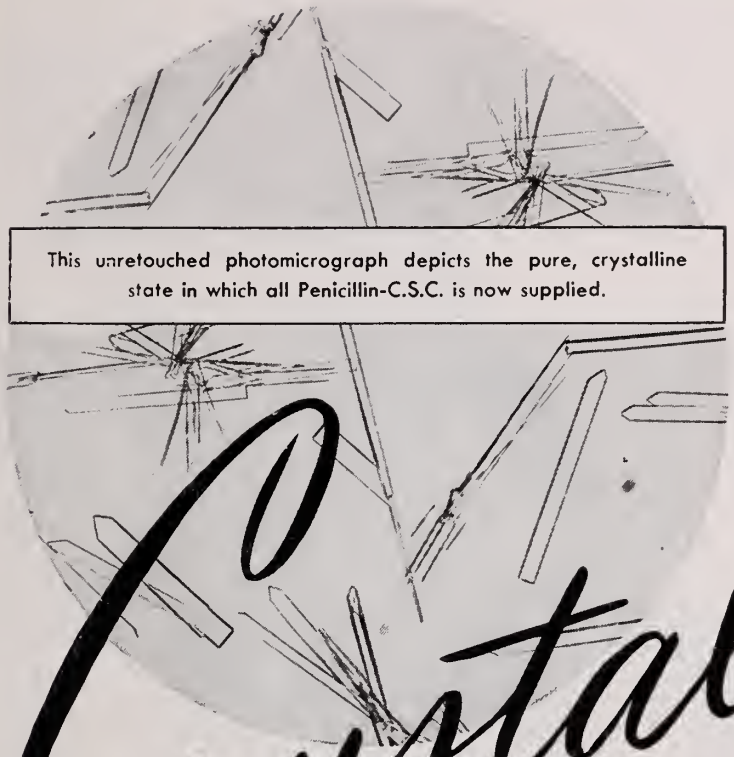
But may we suggest that you make your own tests?

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PHILIP MORRIS & CO., LTD., INC.
119 FIFTH AVENUE, NEW YORK, N. Y.

**N. Y. State Journ. Med. 35 No. 11,590*
Laryngoscope 1935, XLV, No. 2, 149-154

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.



This unretouched photomicrograph depicts the pure, crystalline state in which all Penicillin-C.S.C. is now supplied.

SYMBOL OF PURITY

Crystalline PENICILLIN SODIUM-C. S. C.

As a result of special processes of purification and crystallization, all Penicillin-C.S.C. is now supplied in the form of the highly purified, heat-stable Crystalline Sodium Salt of Penicillin-C.S.C.

Well Tolerated Subcutaneously

In the crystalline state Penicillin Sodium-C.S.C. is so pure that it can be administered subcutaneously even in large doses with virtually no pain or danger of untoward reactions due to impurities.

No Refrigeration Required

Crystalline Penicillin Sodium-C.S.C. is so heat-stable that it can be kept at room temperatures, virtually indefinitely without losing its potency.* It can now be carried in the physician's bag or stored on the pharmacy shelf. No longer need the physician wait until the patient can be hospitalized or until refrigerated penicillin can be obtained from the nearest depot.

*CAUTION: Once in solution, however, penicillin still requires refrigeration.

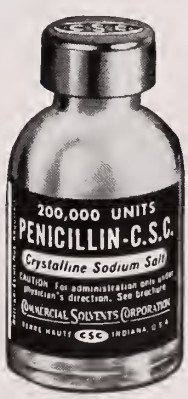
Optimal Therapeutic Activity

Because of its high potency per milligram, Crystalline Penicillin Sodium-C.S.C. exerts optimal therapeutic activity. A recent report shows the advantage of highly potent preparations.[1]

Potency Clearly Stated on Label

The high state of purification achieved in Crystalline Penicillin Sodium-C.S.C. is indicated by *its high potency per milligram*. The number of units per milligram is stated on each vial, thus enabling the physician to know the degree of purification of the penicillin he is using.

[1] "The potency of the penicillin undoubtedly affected the results. The first 15 patients, all treated with the same batch of penicillin, were cured. The next 7 patients were treated with the same dosage of a different batch of penicillin. Five of these 7 were not cured. Assays of penicillin used for these 7 patients showed it to be of reduced potency." Trumper, M., and Thompson, G. J.: Prolonging the Effects of Penicillin by Chilling, J.A.M.A. *130*: 628 (March 9) 1946.



Crystalline Penicillin Sodium-C.S.C. is available in serum-type vials containing 100,000, 200,000, or 500,000 units.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

Penicillin-C.S.C. is accepted by the Council on Pharmacy and Chemistry of the American Medical Association

PHARMACEUTICAL DIVISION

COMMERCIAL SOLVENTS Corporation

17 East 42nd Street New York 17, N. Y.

CSC


COMING THROUGH
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QUALITY
Famous
Narragansett
FAMOUS
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LAGER BEER & ALE
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PHYSICIANS DIRECTORY

CARDIOLOGY

CLIFTON B. LEECH, M.D.
(Diplomate of American Board of Internal Medicine; Internal Medicine and Cardiovascular Disease)
Practice limited to diseases of the heart and cardiovascular system.
82 Waterman Street, Providence
Hours by Appointment
OFFICE: Gaspee 5171
RESIDENCE: Warren 1191

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VINCENT J. ODDO, M.D.
Practice limited to Urology and Urological Surgery
Hours: 2-4 and 7-8 and by appointment
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NATHAN A. BOLOTOW, M.D.
Ear, Nose and Throat
Otorhinologic Plastic Surgery
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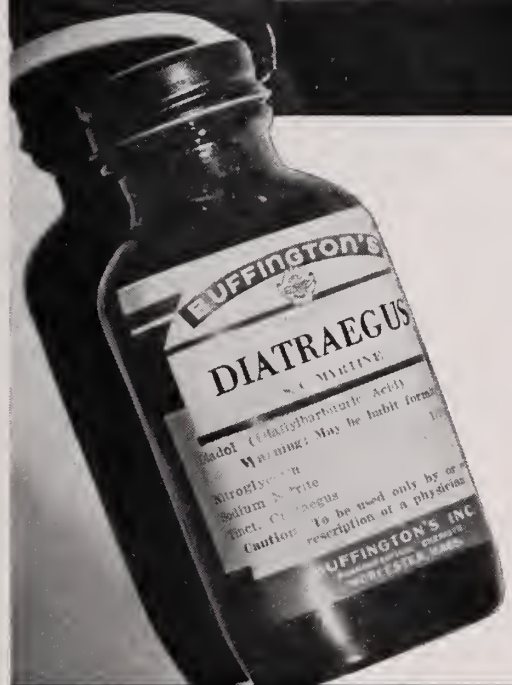
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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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Volume XXIX, No. 12

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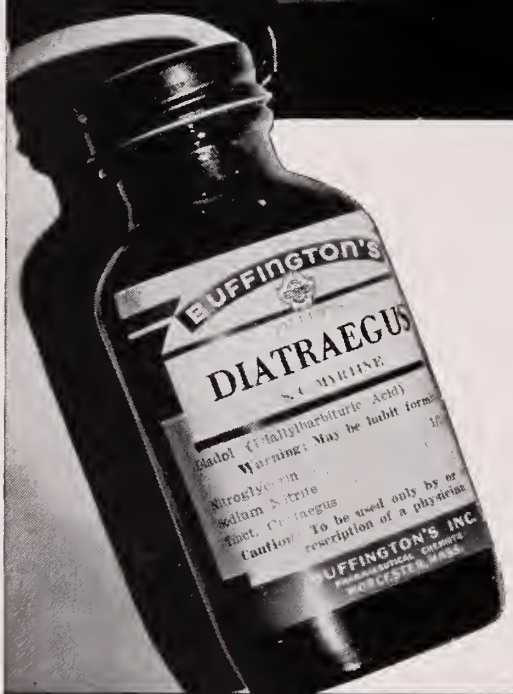
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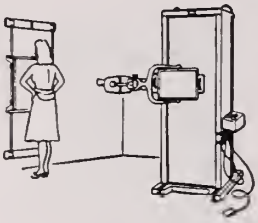
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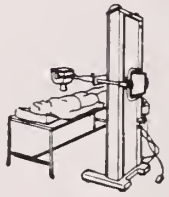
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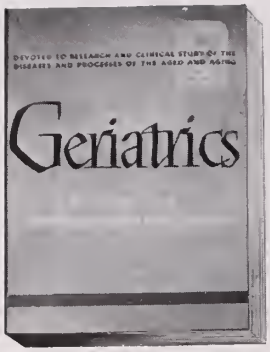


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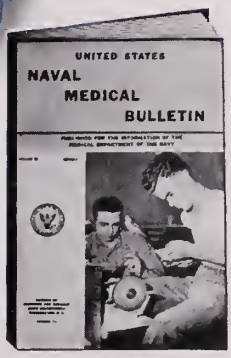
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1. Gunther, L., U. S. Naval Med. Bull., 44:300, 1945.



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ILLUSTRATION BY HAROLD ANDERSON

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A picture of The Good Samaritan provided the inspiration that



eventually led to the founding of Eli Lilly and Company

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MEDICAL ASPECTS OF THE ATOMIC BOMBINGS*

SHIELDS WARREN, M.D.

The Author. *Shields Warren, M.D., of Boston, Mass.; Executive Officer, Naval Medical Research Section of the Crossroads Operation; Assistant Professor of Pathology, Harvard Medical School; Pathologist, New England Deaconess Hospital, and Harvard Cancer Commission; Director, Massachusetts State Tumor Diagnostic Service; former President, American Society for Experimental Pathology, and American Association of Cancer Research.*

The photographs referred to in the following article cannot be reprinted here owing to Government regulations. However, the accurate and vivid description of them as given by Doctor Warren has prompted the publishing of this address as it was originally presented.
The Editors

MR. PRESIDENT and members of the Providence Medical Society, it is a very real pleasure to me to be able to speak to a medical audience about the problems that atomic energy are bringing to the medical profession.

These problems fall into two groups. First, what does atomic energy offer as a tool for research, and second, what does atomic energy offer as a hazard for humanity as a whole. First, from the standpoint of what this new tool in medical research offers to us; —So far as therapy by means of atomic energy is concerned there have been no particularly striking developments. The utilization of the temporarily active isotopes of which phosphorus, iodine and sodium have had the major experimental use, indicates that certain of these offer advantages that surpass the standard type of radiation therapy. But on the whole they do not offer anything in a startling way beyond that of the usual types of radiation therapy and in many ways they do not have any superiority over them.

Their chief value from the standpoint of medical research lies in their use as tracer compounds. The advantage of a radioactive isotope is that such an isotope can be utilized from the chemical standpoint exactly as any chemical can be. Thus radioactive phosphorus is no different in its reactions and its behavior from ordinary phosphorus. Radioactive iron is identical in its chemical reactions and its metabolism in the body with ordinary iron. But owing to their radioactivity, they carry with them a tag, a signal which makes it possible to trace them. For example, we can spot radioactive phosphorus down to ten to the minus fourteenth gram, that is, one millionth of one millionth of a gram, which is almost a matter of one or two molecules of the material. This means that we have been able and are actively following at the present time all sorts of experimental observations as to what goes on in the body under varying conditions.

As a minor illustration I might mention some of the work that Dr. Root did at our own hospital on the problem of resistance to insulin which is familiar to a number of you. The problem came about as to how many cases of so-called insulin resistance were really true resistance to insulin and how many were due to poor absorption of insulin. By the use of radioactive isotopes of zinc instead of ordinary zinc in the zinc insulin it is possible to follow the insulin molecule once injected in the body and see what happens to it. In a number of these insulin resistant cases it was found that the zinc insulin when injected into the tissues became imbedded in local scar tissue and the reason that the patient was apparently insulin resistant was that the radioactive insulin did not get beyond the initial site. Now this could not be worked out satisfactorily by any other method that we have at the present time. Similarly Dr. Hastings in the Department of Biochemistry at Harvard Medical is working out some quite revolutionary concepts in carbohydrate metabolism as a result of the ability to trace the atoms of carbon in the process of carbohydrate

continued on next page

* Presented before the Providence Medical Association, at Providence, November 4, 1946.

metabolism and see where each goes, what happens to it in the course of utilization of the material.

The surface has only been scratched in this type of investigation and I am rather inclined to think that our major advances as a result of the use of nuclear energy will lie in this field as a tool for research, a tracer tool, rather than in the therapy that may be offered. The therapy is useful in a limited field but the research which may be carried on with these radioactive isotopes is practically without limit in its scope.

Now from the second standpoint—what have we got to expect? What are the dangers in the widespread, peacetime use of atomic energy? What are the dangers in its use as a weapon of warfare? Here the danger is essentially that of ionizing radiations. The thing that sets an atomic bomb apart from the blockbusters, the thing that made the difference at Hiroshima and Nagasaki from the bombings at Yokohama, at Tokyo, at Hamburg or in the Rhur, is the fact that not only have we here an explosive force but in addition we have a source of radiant energy almost beyond conception.

This radiant energy falls into two types. First, thermal radiation, a heat surpassing the heat of the sun, and second, ionizing radiation, coming both from the immediate flash of the bomb where there is a flux of neutrons and of gamma radiation ranging all the way from the equivalent of x-rays produced say at fifteen million volts down to those produced at a matter of a hundred thousand volts or more and from the residual radiation from fission. As you know at Hiroshima and Nagasaki the bomb was so regulated that there was no residual effect of any significance. In the first Bikini Bomb radioactivity was a minor factor. As a result of the second bomb there is still a dangerous degree of radioactivity on some of the target ships. I saw the other day a photograph made from a fish, an autoroentgenogram, so to speak, where the fish had been caught, laid down on a piece of paper with sensitive film on the other side of it. A very accurate photograph of the fish was taken by virtue of its own radioactivity.

Now our task at the investigations in Japan and at Bikini was to endeavor to find out as much as we could about the medical and the biologic effects entailed. In Japan we were very fortunate in having the cooperation of the Manhattan District Group under Colonel Stafford Warren whom some of you have heard speak, undoubtedly, and also of the army group under Colonel Oughterson whom some of you may have heard at the New England Surgical Society. We pooled our resources and by virtue of that pooling in Japan we were able to hospitalize about a thousand patients and study them carefully and were able to get accurate casualty studies of a total of some thirteen thousand victims at the two cities.

The biological aspects of the tests at Bikini were planned from two angles. One to supplement the knowledge gained in Japan and to close in the blank on the early changes produced there. We did not get in as you known until five weeks afterwards and during that early period the Japanese were so disorganized no investigation worthy of the name was carried on. We had to see what happened in the early stages and in addition we had to determine through our animals at Bikini what variation in the factors of protection, of distance, by structure in way of the steel in the ships, by water in relation to depth beneath the water line might be determined, so that we might tell with a fair degree of accuracy what might happen in the future to a naval vessel, or a civilian vessel for that matter, that came up against an atomic explosion.

We had a ship to ourselves, an APA, familiar to navy men—one of the large transport vessels to those of you who are not familiar with navy terminology. This ship proved to be very well adapted for its purpose and we brought our surviving animals around after the tests and disembarked them at the Washington Navy Yard at Anacostia and are now following them at the Navy Medical Research Institute just outside Washington in Bethesda. It will be necessary to follow these animals for a number of years and a number of generations. As you know from the observations of the roentgenologists, and as you know from the work of Dr. Muller recently publicized by being the recipient of the Nobel Prize, that the effects of radiation may not be apparent in the first, second or third generation, but it may be many generations before the mutations induced by the radioactivity can be thoroughly evaluated.

I might mention in passing while we are speaking of this, that one interesting observation was made on the high school girls in Nagasaki with the aid of our Japanese co-workers. We rounded up for study a group of girls between sixteen and twenty-one who had been menstruating normally prior to the explosion of the bomb. Less than a third of them were menstruating normally following the bomb. Now there are a lot of problems that have to be reckoned in there. There is the question of psychic trauma, there is the question of relative malnutrition in the bombed area, the question of impaired health, lowered resistance to diseases, but none the less there does seem to be significant evidence that there is a disturbance of an ovarian function in some members of this group. We found testicular atrophy in a fair number of the males who received heavy radiation both at Nagasaki and at Hiroshima and we assume that there is a fringe further out from the center of the bomb at the time of the explosion who are not sterilized but who received sufficient dosage to alter the germ plasm.

Now with this preamble let's turn to some of our slides. When we moved into the Bikini area our main worry was what was going to happen if the weather was bad. Our animals were scattered on twenty-two target ships spread over the lagoon at Bikini. It was a rough job caring for five thousand animals on shipboard. You can imagine how much rougher it would be if we had to leave the lagoon every day to go outside to the open ocean in readiness for the bomb drop and then to come back if the weather was bad. And then to spread our care of the animals out over twenty-two ships. By amazing luck we had a good day on the first of July which was set for the bomb drop and this is what the automatic camera on the island of Bikini—there blow the palms of Bikini in the foreground—registered at the time of the explosion of the bomb. You can see the great cloud that eventually rose to 35,000 feet and drifted far through the stratosphere. This was just starting to rise and you can see on the target ships the smoke is beginning to sweep out. This is only a fraction of a second since the explosion of the bomb. Here you can see how the smoke is beginning to boil up from various ones of the target ships. Here are some of the further target ships. These are LCT's in the foreground, relatively undamaged. Some of our animals were just out of the picture over this way—just on one of the LCT's on the beach, and we had them spread from there clear to the center of the bomb area and far beyond it on the other side, so that we got some of our animals in every range of exposure from virtually none at all to those that were heavily damaged.

Now this is visual evidence of one of the effects of the bomb. This dark streak on the water that you notice is a pressure wave, branching out over the surface of the water, coming from the center of explosion out across the lagoon. These smoking ships are evidence of the thermal radiation that was encountered. And this thermal radiation is the first of the two distinctive features of the atomic bomb and one of the ones which led to a great number of casualties. As we went through the Bikini area we were able to see evidences in there of scorches which showed up on the paint of the vessels, on the material placed on the decks, etc., but nowhere was it as vivid and clear as it was in Hiroshima and Nagasaki.

Here you see the pedestal of one of the mythical sacred animals, the Kaigori, so-called, in the Chogoku shrine. The Japanese assumed that we would protect their shrines and consequently they used this shrine for military headquarters. I will show the orientation of it a little later. And this is one of the mythical sacred animals that was guarding the outside of the shrine. And if you notice this granite pedestal, you can see how the granite was flaked in the portion that was exposed to the bomb. The bomb burst relatively speaking was up here and out of the picture and going down this way. This entire face was almost a sandblast in effect and the more exposed portion of this later region also got the effect of the instantaneous heat.

The next slide brings out a view of the hypo center of the bomb. The bomb burst immediately over the cellar of this little private hospital at Hiroshima. And incidentally we were quite excited when a very hot Geiger reading was reported about over in this region here. And then we lost a great deal of enthusiasm when it turned up some radium had been used on a patient for Ca of the cervix at the time. Here is one of the Torii still standing at the entrance of this shrine about a hundred and fifty yards away from the center. Owing to the fact the form was downward here you will note that the bomb left standing the Torii and this little wireless transmitter. Literally they would have been swept away but where the component was downward their narrow cross section presented to the force of the blast enabled to keep them standing. The headquarters of the second grand army was within this shrine, the Kaigori which I pointed out to you was this white spot over in here.

The next slide is an example of what happened to one of the reinforced concrete buildings. They really built concrete to last in Japan because it has to be earthquake proof and the engineers told me that the specifications were far better than those of any of our own cities. And you can see how this reinforced concrete building, this was at Nagasaki, was virtually crushed by the blast. This is approximately one-sixth of the building on the lee side that persisted. Everyone in the building was killed, not all by the blast, but some of them by the radiation which they received, in spite of the shielding with the concrete.

The next slide gives you an idea of how Nagasaki looks in the bombed area. You remember that the Nagasaki bomb was dropped in a valley, running up northerly and slightly westerly from the harbor and you can see the rice fields here reaching up the side. And this area here had been densely populated. The average density of population was eight persons to every forty-six square feet in this area. So you can figure that they were really packed. In Nagasaki we had approximately forty thousand killed and an equal number injured; in Hiroshima eighty thousand killed and eighty thousand injured.

In the next slide you see a view of Nagasaki looking up to the region that we just saw. The region that we just saw was the other side of this hill here. And this little dog leg of hill came down and protected this region more or less. Here is a

continued on next page

typical Japanese house. One and a half stories, tile roof, thin wooden walls, with mud and bamboo for partitions, meat for any fire or any heavy blast that came along. This was taken from a window of a Shinkoseh school, which had been taken over as a hospital and in which we had a group of the Nagasaki bombed patients. One thing that undoubtedly explains a large number of casualties in these two cities was first that Japanese were too disorganized to do very much in taking care of the victims. It was two days before the first organized rescue party came in either city and then when they did round patients up for hospital care, it was the most primitive type imaginable. Unless they had their own family there to care for them there was no real care. Nursing care as we understood was not existent. The doctors injected vitamins, they put cod-liver oil on the burns, cod-liver oil ointment, they did a little minor bandaging and they gave autotransfusions. That is they would take 10 cc. of blood out of a vein, and inject it into the gluteal muscles. Our blood transfusions or plasma transfusions were non-existent. A few sulpha drugs were used but no penicillin. It is no wonder that the death rates in these hospitals were terrifically high.

In the next slide we see another evidence of the heat, the thermal radiation that was given off by the bomb. This is part of a woman's kimona. This was dark red plaid and as you see the red was burned through, the white here and there slightly scorched but in general untouched. This is a placade in the railroad station at Hiroshima and the figures were painted in here with India ink on white sized paste board. The paste board reflected off the bulk of the radiant heat while the India ink absorbed it. It was burned through and scorched wherever the ink was displayed, but untouched in the white area.

Here are some chairs which were in front of a window at the Red Cross hospital in Hiroshima and you notice the patches of burned plush where they were opposite the window. And this is the shadow between the windows and this is the shadow of the window sill and the wall here and this is where the window fell upon the plush showing the radiant heat which acted upon them.

Here is a bridge across one of the five rivers that go through the delta at Hiroshima and you note on the asphalt surface of the bridge the burned shadow of the post and of the railing. You notice also that the blast came after the heat. The shadow protected the asphalt from being burned and was continuous with the instantaneous heat. Remember it travels at the speed of light, 186,000 miles per second. It travels eleven hundred feet per second. Now by triangulation of these shadows and



the objects which caused them it was possible to calculate with a great degree of accuracy the exact location of the bomb burst. And we were able to find it was dropped at the precise spot desired and that for all practical purposes at the exact height desired. A beautiful piece of engineering, calculation and skill in the aviators that did the job.

To illustrate the sun-like character of this thermal energy, the great speed with which it came I choose this picture. Here you see a board fence at Nagasaki. This board fence is made out of cryptomeria wood about like our soft pine and this showed a uniform carbonization as a result of the radiant energy. But where grass had stood at the time of the bomb burst in front of it, the grass was enough to protect the wood. The shadow, the unburned shadow of that grass persists here, cast before the blades of grass had time to wave or wither. Similarly you see how this pole, which I had lowered a little, this wire which I had raised a little had also protected this wood from carbonization. Probably a few thousandths of a second was enough to produce this burn. When the heat hit humans it gave first and second degree burns in many instances and those who were closer in received third degree burns. This man shows, not too well, flash burns of his cheek and his ear. You can see the swelling of the ear somewhat and some of the scarring of the face. Note the epilation of the scalp.

That is the second distinctive feature of a burst of atomic energy from one of these bombs. The freeing of ionizing radiation as well as thermal radiation. And he has lost all of his hair. Complete epilation of the scalp was not infrequent in many of the more seriously ill. It began to appear a few days to two or three weeks following radiation and was quite marked at the time we saw them in mid-September and October. In fact one of the ways we use to pick out some of the survivors

of the bomb for study was just to walk through nearby villages and when we saw anybody epilated or anybody with a first or second degree burn we would ask them where they had been and if they had been in a region that we wanted for study we would ask them to come in the hospital.

Here we see one of the typical beds at the hospital at Omura, a naval hospital which we took over and where we harbored a considerable number of the atomic bomb victims. And here we see again a partial epilation. This lock of hair really belonged on the other side but she combed it over because she thought it helped her appearance. Again you can see the first degree burn of the cheek and of the neck and the epilation almost complete on this side of the head due to the ionzing radiation.

I might say that the teapot is universal. Water is unsafe to drink anywhere in Japan unless boiled and tastes so bad when it is boiled they make tea to make it drinkable. This is one of the sake bottles which help to keep the patients a little cheered. They have the cotton blankets and quilts to keep them warm.

This woman had at the time this picture was taken a white blood count of approximately eleven hundred, a red blood cell count of about two and a quarter million and she subsequently died of an aplastic anemia because of the bone marrow damage induced by the radiation that she had received.

Here we see a man. This is a Javanese, prisoner of the Japanese. He was working in a prison camp in Nagasaki down the river from the burst of the bomb. He was working stripped to the waist and you can see here the lines of his belt and trousers. He has assumed for us here—this photograph was taken on one of our hospital ships, the Haven, which was evacuating him—that exact position he occupied at the time he was watching the objects falling down from the plane and wondering what they were before the burst occurred. And as you can see he has these second degree burns over the exposed areas and is absolutely untouched where the shadow of the forearm fell across the chest. Note also on his left arm, how the upper part of the arm was shielded by the body and just part of the extensor surface which protruded over beyond the body and got into the rays of the heat from the burst was caught. These sharp demarcations were a very characteristic feature of the burns that we saw.

This man had a transient leukopenia, a transient anemia and with the aid of several transfusions recovered and to the last of my knowledge, which was some four months after the exposure, he is perfectly well. He was not close enough in to have any epilation as you can see from the condition of his hair.

This is a girl which I meant to show earlier with the example of the dress. You remember the plaid with the dark areas burned out. And she got these third degree burns where the dark marking of the plaid was, third degree burns up here where she was unprotected. In this region protected by the shadow of her hair and where the cloth was white very little effect is apparent.

Some of the traffic cops in Nagasaki were very interesting because they wore white shirts with a black cross on the back to make them stand out for visibility in the traffic. They were unburned beneath their shirts, some of them, but the outline of this black cross was very clearly burned.

Now here we leave Japan and the Japanese and come back to Bikini. This is the second test. This is the most appalling spectacle that I ever expect to witness. I was actually scared as a matter of fact. This is what we saw the first instant after the burst. You can see the target ships in the foreground here. You can see the cloud just beginning to fray out from it a little bit. And here in this instant we have eight million gallons of water starting up in the air. You note that there is no disturbance yet in the target ships. There are no waves. This was practically taken from the same vantage point as the other, in fact, these palm trees down here are exactly the same palm trees that you saw in the first picture.

That was an intensely glowing mass. As near as I could make out about the equivalent brightness of the sun. Much less than in the air burst because much of the light, much of the heat, was absorbed by the water.

Here is the next stage of it. The cloud is beginning to scatter out. The water is on its way up. Here are the waves beginning to come out. These waves, you can get the scale, this is a battleship here and you can figure from the mast how high this initial wave must have been. It petered out very rapidly when it reached Bikini and here they were only four or five feet high. But they were really something at the start as you can see. Now note that this is not only a mass of water but of superheated steam and of radioactivity.

And here is what it looked like a few seconds later. This great mushroom of water, steam, laden with deadly radioactivity spreading out with a column of solid water here. There is the battleship in the foreground for the scale, as you note this ship up there, and this is again a solid column of water reaching through this about up to this region here. And from this rain, down on the target ships which you see scattered along here, the water was made radioactive by virtue of the neutrons that have been discharged into it, surcharged with radioactive sodium, with radioactive chlorine and also contain-

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ing some of the fission products of the bomb. And the cloud is just starting to climb at this point here. The cloud in this case of course did not go as high as in the air burst. In the first it went thirty-five thousand feet and in this it went only about half as high.

Now it was in the ships that received this rain of radioactivity our animals were placed. And in the study of those animals we had therefore two things to consider. Not only the initial radioactivity which we had to work with in the first test, testable, but we had also the problem of residual radioactivity from the induced activity in the vessels, and included activity in the water and the fission products from the explosion itself. So that here our relative loss of animals was greater than in the first test - - - in the first test we had the advantage of the Japanese experience and were able to disperse our animals so that only 10 per cent of them were immediately killed and the great bulk of them were available for study as sick animals following the test which was of course the most valuable information for us.

In the second test, however, the residual radioactivity had delayed us before we could go back on the ships to get the animals off. It was such that they received much heavier radiation and many of the animals had been killed by radiation by the time that we had recovered them.

In any discussion of this experiment it would be quite remiss not to put in a word of appreciation for what the Radiologic Safety Section under the guidance of Colonel Stafford Warren was able to accomplish. In the entire operation of these two tests with forty thousand men, not a single individual was damaged from the standpoint of radioactivity or the effects of the bomb. That proves a major accomplishment in preventive medicine. They had a fine group of monitors to check the radioactivity of the water of the various target ships and to tell us when it was safe to go aboard and how long it was safe to stay aboard. With all due respect to monitors, I'm a little skittish about radiation and so we did our own confirmatory monitoring in the section after the radioactivity monitors told us it was OK. We did not find any deviation from their results but we thought any extra check was worthwhile. The monitoring was so good that we could tell where it was safe to go in the lagoon, when it was necessary to shift our anchorage to distant points away from the radioactive deposits in the water; when we could run our evaporators and get distilled water to use and when we had to shut down and go outside in open ocean to make our water. The degree of protection which the Radiologic Safety Section offered us was really amazing and thoroughly gratifying.

In the rescue of our animals some of the work had to be very snappy indeed. We had one ship where two minutes was the length of time to get tolerance dose so we had to organize our teams highly so that we could get our animals off, for two minutes was the longest time we could stay aboard. Other ships we could take a longer time.

The impressive thing in the way of driving home the lesson of the dangers or risk of residual radioactivity, was to be forced to stand by, to see the entire salvage force required to stand by while the Saratoga sank. There she was, we could have put her in the shallow water if we could have gotten nearer, or pumped her out, for she just settled slowly and it took her hours to sink. She could have been rescued had it not been for the radioactivity in the water near her and the radioactivity on the vessel itself. This brings home very forcibly, the fact in the use of atomic energy we have to consider not only the immediate risk but the residual risk as well. And even in experimentation with radioactive isotopes at the present time, if you deal with materials that have half life of any appreciable duration one problem is of disposing of them when your experiment is over.

Fortunately the Manhattan District, had worked out certain rules that had to be followed in the way of the disposal of the material. As you realize there is no more warning in regard to the radiation given off by the atomic bomb than there is to the radiation of x-ray or radium. You don't feel it at the time, it is afterwards that you feel it.

One of the very important things we must do with atomic energy, if nuclear energy is to be used more widely in peacetime, is to map out some satisfactory and easy method of picking up radioactivity. A Geiger counter is all very well but if you have a counter set too sensitively it will jam.

So that we have yet to find a much simpler and much more foolproof method of measurement of radioactivity before it will be permissible to use nuclear energy on a widespread scale for peacetime purposes.

So far as I can see if we depend upon therapy, in the utilization of nuclear energy, let us say, in the treatment of carcinoma or something of that sort, we are going to be disappointed. The good that it will do will be far less than the harm that it may do. On the other hand, considered from the standpoint of a tool for research, as tracer substances, we can learn much more of the metabolic processes of the body, of the mode of action of drugs, of the way in which toxins take effect, etc. There it will be of enormous value to us and well worth all the efforts that have been entailed in its development.

One final word. Many of you probably are very critical of the use of these bombs in Japan, just as

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THE FUTURE OF MEDICAL RESEARCH*

THEODORE G. KLUMPP, M.D.

The Author. *Theodore G. Klumpp, M.D., of New York City. President, Winthrop Chemical Company; Executive Director, American Foundation for Tropical Medicine; Former Secretary, Council on Pharmacy and Chemistry, American Medical Association.*

THE little auk is a legendary bird that flies backwards to keep the wind out of its eyes and because it is more interested in seeing where it came from than where it is going. Let us for a moment imitate the little auk and look back about a century.

A short time prior to 1844, the steamboat, the steam engine, the cotton gin, the electromagnet, the telegraph, the sewing machine, the harvester, and the bicycle had been invented. Woehler had synthesized urea. Davy had isolated sodium, potassium, calcium, magnesium, sulfur, and acetylene; chloroform and chloral had been discovered; atropin had been isolated; and the anesthetic effect of ether had become known. The impact of all these discoveries was too much for the U. S. Commissioner of Patents of that time. Like the little auk he looked back at what had been accomplished and it made him dizzy — so much so that he announced: "We see the arrival at that period where human improvement is at an end." During the next few years the Bessemer steel process was invented, Perkin introduced aniline dyes, cocaine was isolated, Kolbe synthesized salicylic acid, and, somewhat to my regret, the lawn mower and the typewriter were invented. These discoveries went to the head of the U. S. Commissioner of the Interior who was also flying backwards. He stated in 1875, "New materials and new inventions have now transformed our society into its final phase, for scientific inventions can take us only a little way further."

These distinguished public officials were not the only little auks in our community. When I finished medical school in 1928 we were deep in the trough of therapeutic nihilism. Chemotherapy's future was its past. Bacteria were considered to be so similar to the living cells of the body that anything capable of killing them would also destroy the living tissues of the body and thus do more harm than good. In fact, it was argued that bacteria were able to thrive in the body for the very reason that they had cleverly succeeded in counterfeiting the biological chemistry of living cells. The main hope seemed to lay in immunology, serums, and vaccines. Our best medical investigators were thinking along those lines. Drug houses and public health laboratories were also principally interested in the future of biologicals. Some of them were making large investments in horse farms for the production of antisera when Prontosil burst upon the world to inaugurate the second great era in therapeutics. Almost overnight chemotherapy was resurrected from the dead. Even if nothing else were discovered, you and I are privileged to be living in an age which, compared with the pace of progress in the past, may be regarded as the golden age of therapeutics. It is also most encouraging that American chemists and clinical investigators have at last caught up with the Germans, and together with English workers, seem to have wrested leadership from them.

But how much has been discovered? Are we now prepared to repeat what the Commissioner of Patents said in 1844? Thrilling as our discoveries in medicine have been, we have really accomplished very little in relation to the great things that remain to be done. We have only succeeded in establishing a firm beachhead on the vast continent of medical science that remains to be explored and conquered. A number of substances that depress or stimulate various functions of the body have been discovered. As adjuncts to living they are important but they do not substantially affect the fundamental processes of life itself. We have discovered substances that have an inhibitory effect upon a few parasites and bacteria, and we have succeeded in synthesizing agents that appear to stimulate the action of three or four of the many hormones secreted by the body. Likewise, we have found out something about the constituents of a few organs and body secretions and have succeeded in recovering some of their active principles. We have taken food substances and by relatively simple degradation studies we have found out something about their constituents. We have even succeeded in synthesizing, not the foods themselves, but a few of their simplest building blocks. We have done a great deal of explora-

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*Presented before Medical Grand Rounds, Rhode Island Hospital, June 29, 1946.

tory descriptive work in medicine, but in changing the course of nature to suit our purpose, we have hardly scratched the surface. It was Will Durant who said that most of man's progress has come from not letting nature take its course.

We look upon the discovery and manufacture of penicillin as a remarkable accomplishment. But is it really so remarkable? Fleming made his original observations in 1929, and we sat around for 12 years before we got on to the idea that his discovery could be applied to the treatment of disease. And even here, just how clever and ingenious has been this remarkable organ of ours, the human brain? We have pointed with pride at our brilliance in providing something like the right food for the lowly mold, even though every housewife has had occasion to learn something about the feeding habits of molds on bread and jellies. Nevertheless, we have left it to the mold to do the real chemistry for us. Although penicillin has excited perhaps more medical and chemical interest than any discovery in a decade, at this point we are not even sure of its exact chemical structure. But we have found the right solvents to separate the unused food from the penicillin, and we dry it. Penicillin notatum is one of the lowest forms of life, it can't think, it can't talk, it can't even move and get out of its own way, and yet our scientists have not yet succeded in duplicating what to this mold must be an exceedingly simple routine chemical turn.

Dental Caries

Take another serious problem with which we have wrestled for many years. There are in our mouths certain structures composed largely of calcium phosphate. A chemical reaction occurs, in the course of which the calcium salts of our teeth are thrown into solution and we have what is known as dental caries. Despite the fact that this chemical process results in widespread suffering and disability, we have not yet determined exactly how it happens. We are not sure of the factors involved, and we have done very little, if anything, to prevent dental caries. And yet when we consider the problem from the standpoint of chemistry and bacteriology, it does not appear particularly complicated. From an objective scientific point of view it looks as if it were something we should have solved long before this.

We have nibbled at the edges of such serious conditions as arthritis, rheumatic fever (perhaps the No. 1 health problem in this country), tuberculosis, undulant fever, diabetes, allergy, and exophthalmic goiter but we have not by any stretch of the imagination mastered them.

I mention these things because I want to show you that we have only scratched the surface and so emphasize how much remains to be done. I want to show you that the Commissioner of Patents a hundred years ago was wrong, and anyone who thinks like him today is still wrong.

Longevity

But what are the most important things that remain to be accomplished? I can answer that by asking a question. How many of you would like to live in good health for 130 years? Is that an absurd thing to ask? I think not. It is biologically possible for many of our children or our children's children to live that long. According to one theory, in the animal kingdom the life span of a species is five or six times longer than its period of maturation. On that basis the normal span of man should be from 125 to 150 years, and indeed there are records of individuals living as long as 130 years. In 1938 the Russian scientist Bogomolitz sent an expedition to the Caucasus to study 12 persons between the ages of 107 and 135. Last week a man 104 years old was arrested for gambling in New York City. Now if some individuals can live that long two things are possible of attainment: the long-lived individuals can be made to live a little longer and the lives of many more and eventually most human beings can be prolonged to that ripe old age. But to achieve this we must learn a great deal. We must learn a great deal more about biological chemistry, we must learn infinitely more than we know now about the chemical factors that influence longevity, and then through medicinal chemistry we must modify those factors in the direction of good health and long life.

It has been said that the way to live long is to come from a line of long-lived ancestors. A few years ago I had the privilege of discussing this problem with the late Dr. Llewellys Barker, professor of medicine emeritus of Johns Hopkins University Medical School, who was then a very old man. He agreed with me that to talk about long-lived ancestors doesn't explain anything. It simply means that the individuals in a long-lived line inherit a pattern of chemical behavior that is conducive to long living. The important thing to find out is in what respect these individuals differ from those who are not so fortunate. You who examine large numbers of patients coming to the hospital must have been struck, as I have, with the observation that some are physiologically and anatomically through at forty, presenting all the signs of extreme deterioration and senility — arteries hard and calcified, high blood pressure, and a heart that was failing at its work. On the other hand, we encounter others twice as old with a twinkle in their eyes, elastic minds and arteries, and very few of the manifestations of deterioration and degeneration.

At the present time we actually know pitifully little about the factors that influence the rate at which we go down hill. Indeed we are absolutely certain of only one fact. Overweight is highly prejudicial to long life. The very old person is almost

invariably lean and often very thin. But what else influences longevity? What diets, for instance, predispose to long living? Should we eat much meat or little? Is a vegetarian diet beneficial, should we drink lots of milk, or Bulgarian bacillus milk, or lots of water instead? How about eggs? Dr. Leary, the distinguished Boston pathologist, believed that food rich in cholesterol, such as eggs and cream, predispose to arteriosclerosis and should be avoided, but most pathologists disagree with him. How about exercise and physical work? Should we keep on exercising, or should we take a great lawyer's advice to the effect that when you feel the impulse to exercise coming over you, sit very quietly until it passes off, and then just keep on sitting. Or should we follow the adage that hard work never killed anyone?

What about fresh air, sunshine, vitamins, vacations, 8 hours of sleep, cold baths, sexual activity, alcohol, and tobacco? There are opinions on these questions, but from the standpoint of scientific proof, very few established facts. Some years ago, the late Raymond Pearl studied statistically the mortality records of smokers and nonsmokers. He came to the conclusion that smoking had an adverse effect upon longevity. He may be right, but I am convinced that his studies didn't prove the point. All he showed was that smokers don't live as long as nonsmokers. And the reason I think he failed to prove it is this: As a statistical group there are other significant differences between smokers and nonsmokers. The smoker is apt to be a more venturesome nervous type. He is the fellow who has to be doing something, who has to keep his hands occupied. He places a high valuation on sensual stimuli. The nonsmoker is a fellow who successfully resists all the temptations to smoke that in our present-day society bombard him every day. As a group the nonsmoker must represent a less nervous, more placid, sterner, temptation-resisting, less venturesome type. Is it not possible that these inherent differences in constitutional and nervous characteristics are factors that influence the life expectancy of these two groups, and may actually overshadow the effects of the smoking itself? One thing is certain, many smokers have lived to a ripe old age. This proves only that smoking is not incompatible with long life. But it does not prove that smoking does not shorten life, and in the end Raymond Pearl's conclusion may be correct though his data may have failed to prove it.

It is clearly apparent that as far as the cellular elements of our bodies are concerned we could, as a species, live many years longer. The cells of our body are capable of dividing and renewing themselves almost indefinitely, even as the simple paramecium. Incidentally, barring accidents the paramecium possesses a kind of immortality in eternally dividing, growing and dividing again. But man's complicated large mass of differentiated protoplasm requires an internal transportation system, his circulation, and this appears to be the unit that is the least common denominator of longevity, the limiting factor. It is this that will have to be made more enduring if we are to achieve an age of man that is substantially greater than we now enjoy. But this is in the last analysis a chemical problem. The aging of our blood vessels is accompanied by a loss of elastic fibers and a deposition of scar tissue and calcium salts. This is arteriosclerosis. But arteriosclerosis does not happen by spontaneous degeneration. There are subtle chemical changes, mediated by changes in endocrine functions, which lead to the structural manifestations recognized as aterioscleroses. We have learned to detect the obvious structural end result, but we know nothing (I think I am justified in using the absolute term) about the functional chemistry that leads to hardening of the arteries.

Cancer

In considering the problems that confront those interested in man's welfare, cancer is among the most important. In a sense, cancer is a biological accident, and of the accidents that befall us it is the most destructive. It kills more human beings than anything else except heart disease. There are two roads to the conquest of cancer. The first is the destruction of the cancerous cells by means of some agent having a differential lethal effect upon them, sparing to some extent the normal cells of the body. The important factor in this equation is the extent to which the normal cells are spared. We have been walking down this road a long time with injections of lead, arsenic, and X-ray and radium, but we have not traveled very far. Radio activated elements and the nitrogen mustards are now being tried. They may carry us farther along and add to the lives we can save. But even these weapons do not offer hope of solving the problem of cancer which is more deeply fundamental to biology and biological chemistry than any process of simple differential destruction. Surgery is, in some cases, a very effective and skilled mechanical application of the same principle, but it is a primitive approach to the problem which, as you and I know, sooner or later finds itself confronted by the stone wall of vital structures that cannot be extirpated.

All cells of the body are part of a highly organized system, and as units in this complex society they are subject to very exacting central control. Their coming and going is carefully regulated from headquarters. Sometimes a cell or perhaps a tissue goes off on a spree of reproduction, which we call a neoplasm, or cancer. But we don't know why it does this. We don't know whether this is the result of rebellion, a condition in which the controls are

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as they always were, but an individual unit runs amok, or whether something has happened to the controls permitting a cell, or cells or tissue, to resume its once accustomed role of division at an accelerated rate. There are many biological facts, too numerous to recite here, that persuade me toward the view that cancer is probably a combination of both factors, but the important aspect of this speculation is this: The changing pace, and sometimes even static periods in the progress of a cancer suggest that some element of control persists even in the case of highly malignant tumors. It is already possible in certain forms of cancer to strengthen this control so that the rate of multiplication is appreciably slowed down and sometimes apparently stopped for long periods. I refer principally to the work of Huggins with castration and female sex hormone therapy in cancer of the prostrate, and the very recent observations of Herman and others on testosterone in cancer of the breast. In my humble estimation these studies are the most significant and important contributions that have ever been made in pointing the way to the understanding and control of cancer.

And this leads me to the second road toward the conquest of cancer. Eventually we shall find other internal secretions that regulate the growth of cells of the other tissues of the body. They are there, they must be there. The orderly growth, development and repair of tissues in their proper sequence and to their proper end point cannot take place without extra cellular coordinators and regulators. Muscles, bones, connective tissue, vessels all grow in harmony, and in the processes of menstruation and pregnancy we see a repeated and wonderfully integrated evolution and involution of many different structures, tissues, and cells. Somewhere in this process lies the secret of cancer. But we have gone after this precious information like Klondike prospectors each with his pick and pan turning up a little gold. This is a problem that is worthy of a better, bigger, more intelligently mobilized effort.

Dental caries, old age, and cancer are not the only unsolved problems before us. If you want to gain a comprehensive idea of what remains to be done, you need only consult the catalog of the causes of death and the classification of diseases. Every cause of death and every illness suffered by man or useful animals is an unsolved problem. After you have looked up what we know about each one of the conditions listed and leave a generous margin of reserve for new diseases which are constantly making their appearance, you will have some impression of the vast territory that remains to be explored and conquered.

In the entire war we suffered a little more than 1,000,000 casualties of which about 250,000 were deaths. But approximately one million Americans die each year from chronic diseases, and another half million from acute conditions. In 1943, it has been estimated, there were 25 million individuals suffering from chronic ailments with a total disability of one billion man days. It is a shocking commentary on the state of the nation's health that almost six million men in the prime of life, one out of every three examined, were found to be medically unfit for military service. Analysis of the causes of disability show that this situation is largely due to unsolved shortcomings in medical knowledge rather than derelictions in medical care.

Brains and two billion American dollars produced an atomic bomb. American brains and adequate financial support can produce equally spectacular results in saving lives. We have the brains but up to the present we have not even been penny wise in our spending. This is perhaps due to the fact that the public has been largely unaware of how little is actually being spent for medical research. Until the era of the atomic bomb, few appreciated fully that even in science it takes money to produce results. The cost of the atomic bomb is an easily remembered yardstick against which we can measure what we can afford to spend to save lives. The most serious group of diseases are those of the heart and blood vessels which in 1943 killed more than half a million, and were responsible for the disability of some eight and a half million persons in the United States. And yet it has been estimated that we devoted in 1944 the paltry sum of $615,000 for research in these diseases. In the same year more than thirty-one million dollars was spent for cigaret advertising. Arthritis does not ordinarily kill but there are over seven million in the United States afflicted with it. And yet the amount spent for research in arthritis is so small that it cannot be found. Cancer caused the death of 166,848 individuals in 1943 and it was estimated that there were close to one million active cases in the same year. We thought enough of cancer to spend almost a million dollars for it of which only a small fraction went for the study of the cause of cancer. But at the same time a single company could spend almost nineteen million dollars for the advertisement of soap. There were 57,005 deaths from tuberculosis and approximately 680,000 persons with the disease in 1943. For this we could only afford $865,000 for research, while at the same time the Department of Agriculture received appropriations of $40,000,000 for research and an additional two million dollars for white-pine blister rust control. During the war the Office of Scientific Research and Development devoted fifteen million to medical research, but American business spent more than a billion dollars on war advertising.

These are a few examples to illustrate that what we lack fundamentally is a proper sense of values.

Like "Through the Looking Glass" everything is upside down. Even Dr. Vannevar Bush who is one of our most forward looking scientists asks for an initial appropriation of five million dollars and an ultimate maximum of only twenty million dollars for medical research for the entire United States, from a government that can afford to spend forty million dollars a year for agricultural research. Perhaps Dr. Bush's restraint is motivated by what he thinks he can get from a people who are not yet awake to the importance of medical research. In my opinion we are attacking concrete fortifications with pop guns. In comparison with research in other fields, plastics, metallurgy, petroleum, communications and transportation, medical research looks and is small-time and amateurish. A comparison of the money and manpower behind research in the mechanical sciences with that devoted to medical research will reveal why the science of saving lives and preserving health has not progressed more rapidly. John Hodgdon Bradley in "Patterns of Survival" states, "It is odd that the nature of stars and the behavior of gases should have stimulated far more and far abler inquiry than have the nature and behavior of men. To be sure, they are more gratifying subjects for study because they are more simple, but man can live without knowledge of stars and gases whereas he is finding it increasingly difficult to live without knowledge of himself. Without such knowledge he is finding it increasingly difficult to benefit from his vast and growing knowledge of everything else."

In planning the future of medical research we must not permit individuals to rise to positions of great influence or power over the subject matter of medical research. Authorities measure the cloth in terms of their own knowledge and experience. If it fits what they already know it is good and approved. If not, it is rejected. In other words, learning stops at the boundary of their experience. On the other hand, great progress, new discoveries, new ideas, only start at that boundary and go beyond. It is not new until it does so. But the powerful academician, the director general, the great pooh bah or whatever one calls him often refuses to acknowledge or accept such an advance because it does not ring true with his experience. The danger is that because of his totalitarian influence he will restrain those who would stray from the well paved road into the unknown. This has been the history of science. It happened to Pasteur and it is happening today. That is the danger of powerful Academies, governmental research and any type of authoritarian regimentation of science. To prosper best the direction of research must not be controlled by purse holding administrators or ex-scientists with a flair for politics and a lust for power. It must be free and competitive. Its direction must be guided by many scientists working together in setting broad objectives but competing in independent groups in pursuing those objectives. Our great industrial achievements were built on competition and we must take a leaf from this notebook and apply it to medical research. Governmental research is conducted under the sway of the classic philosophy that there can be no competition with government. If necessity is the mother of invention, its father is competition.

If we are wise and worthy of a nobler destiny we can turn the lesson of death and destruction to the constructive task of building a secure foundation for health and long life. In developing a program for the promotion of science we must give medical research the attention it deserves in the pattern of the American way of life.

MEDICAL ASPECTS OF THE ATOMIC BOMBINGS

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I was before I went over there. I thought it too bad we didn't just tell them that we had the bomb or that we didn't drop it on the herds up in Hokkaido as a demonstration and let them know what we had and let it go at that. However, when I talked to some of the leading Japanese both in the Japanese Army and the Japanese Navy they told me that the dropping of the bombs actually saved many Japanese lives as well as many American lives and they were glad that it had been dropped. To surrender to ordinary warfare would be to lose face and consequently they could not surrender because it is better for a Japanese, particularly a prominent Japanese, to die rather than to lose face. However, when the atomic bombs were dropped, here was something supernatural, something which no Japanese would understand at first, something which was beyond their means of combatting and this gave them a means of surrendering and saving their face. It meant that the war ended when it did instead of being a matter of fighting valley by valley, island by island until millions of Japanese and hundreds of thousands of Americans were fruitlessly killed.



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THE 100th ANNUAL MEETING

When the Providence Medical Association holds its annual meeting on Monday, January 6, 1947, it will be officially recorded as the one hundredth annual meeting of the Association. In view of the fact that the Association actually was started on January 31, 1848, and it held its first annual meeting in that year, some explanation of why the meeting next month is designated as the one hundredth meeting is necessary.

The recorded history of the Providence Medical Association reveals that its organization was started when a group of physicians met in the office of Dr. H. W. Rivers, on January 1, 1848, for the purpose of forming a Providence Medical Society for the mutual benefit of the members. A committee of three doctors was formed to prepare a constitution and by-laws, and to draw up a fee table. This committee held meetings on February 5 and 14 of that year, after which its report was presented for approval by all the physicians in the city. After the February 14 meeting the group adjourned officially to the date of its annual meeting held on March 6, 1848, at which time the first officers were elected, with the honor of being the first president going to Dr. S. Augustus Arnold.

As the by-laws of the Association originally drawn provided that the annual meeting should be held on the first Monday evening in March, the records reveal that the second annual session was held on March 5, 1849. From then on there was an unbroken series of annual meetings held during the month of March until Dr. W. A. Risk, treasurer of the Association, called attention at a meeting held in December, 1912, that the fiscal year should begin with the calendar year. His motion making such action effective as of January, 1914, was unanimously adopted by the membership. Consequently, the sixty-sixth meeting of the Association, held March 3, 1913, was the last to be conducted under the provision of the old by-law. Then on January 5, 1914 the procedure of having the annual meeting on the first Monday of the first month of the year was inaugurated to be continued until the present time. Thus, we come into 1947 with the hundredth meeting of the Association.

It is fitting that thought be given at this time to plans for the centennial of this Association which will be held in 1948. A committee has already been formed to start preliminary plans, and undoubtedly much work will be accomplished during the coming months. The entire records of the Association have been microfilmed and much interesting data will be prepared from these records.

REGIONAL FRACTURE COMMITTEE

Elsewhere in this number of the JOURNAL appears the report of the organization meeting of the Regional Fracture Committee of the American College of Surgeons, under the chairmanship of Dr. Henry McCusker. It is good to know that the Committee is renewing activities necessarily stopped during the war.

The treatment of fractures had received a great impetus in the right direction before the war started. War surgery involving bones is largely another matter. Rarely in peace times does the fracture specialist encounter the tremendous mutilations so common in war. There is no branch of surgery where right principles of treatment, promptly instituted, are of more value. A poorly handled fracture may not result in death but in a lifetime of disability.

Great advances in fracture work have been made of late years and the American College of Surgeons have played a good part. In New England, goaded by the dynamic Dr. Charles L. Scudder, of Boston, valuable meetings and organizational activities were proceeding most satisfactorily in the pre-war days. We trust these may be revived and that our local committee may collaborate with them as well as promote good and instructive work in our own communities.

KENT COUNTY HOSPITAL

Great credit is due the physicians of Kent County for the initiative and foresight in planning for a hospital for their community. Not only have the Kent County doctors drafted enabling legislation to permit the establishment of a hospital in their county, but they have also been willing to contribute to the expenditure necessary for a survey of the area to decide the type of hospital necessary to meet the medical and surgical needs of the people of Warwick, West Warwick, East Greenwich, Coventry, and West Greenwich. The present plan calls for a seventy-five bed hospital to be erected with surgical and service units designed for 150 beds to facilitate expansion when need for the additional beds becomes apparent. The same organization that will conduct the drive for the Rhode Island Hospital Fund has been solicited to carry on the campaign for the Kent County Hospital which will require an estimated $750,000.

The County Medical Society, through its committee, has taken the necessary steps for organization and has invited representative citizens to serve as a board of trustees. Heading the board is Dr. Arthur H. Ruggles, Superintendent of Butler Hospital in Providence, and also President-Elect of the Rhode Island Medical Society.

There is no reason why Kent County should not be able to support a hospital. The 1940 United States Census shows that it has a population in excess of that of Newport County which has for several years maintained a very excellent hospital in the city of Newport. In addition, the outstanding development of voluntary hospitalization insurance through the Blue Cross in this state has resulted in an enrollment in Kent County of almost 35,000 subscribers. This percentage for the area is higher than the state average and it gives assurance that a hospital in Kent County would be adequately subsidized by the Blue Cross if by no other means.

In spite of the fact that the hospitals in the greater Providence area are planning additions and expansions it is perfectly apparent to students of the question of hospital care in this state that even the expanded facilities will be taxed in view of the increasing use of hospitals by the public generally. With no hospital services available between the Providence City line and Wakefield where the sixty-two bed South County Hospital exists, the presence of a new hospital in Kent County, third largest county in the State in area and the second ranking one in population, appears not only necessary but vitally important in the extension of medical and surgical care to the people in this State. The provisions under the federal Hill-Burton Bill will allocate but limited sums to Rhode Island for hospital buildings, and therefore it is apparent that our community developments must be by the voluntary process. The drive for funds in March for the Kent County Memorial Hospital should receive the support not only of the residents in that area, but also of those throughout the State.

RECIPROCITY IN MEDICAL LICENSURE

Inasmuch as medical licensure is reserved to the various states there is naturally a wide variation in the licensing requirements for doctors. In the matter of reciprocity there is much confusion. For example, twenty-six states recognize the medical licensure of only certain specified states. Four states have no reciprocity. In three states all applicants for reciprocity must submit to an oral examination. In two, a clinical examination is required.

One of the first constructive steps towards the possible solution of this problem, for New England at least, is the action of the Council of the New England State Medical Societies in voting to invite the Secretary of the Medical Examining Board in each of the Northeast states to meet with it in January for a discussion of this vexing situation.

The action of the Council of the New England State Medical Societies has resulted from an interesting report prepared by one of its sub-committees at a recent meeting in which several proposals were advanced, among which were the possible uni-

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fication of state licensure requirements for medicine, the possible validation of the certificate of the National Board of Medical Examiners in all the states, possible adjustment of state to state differences in the Basic Science Laws, and some method of providing for lower reciprocity fees where they are too high. Out of the discussion of this problem the Council drafted a resolution to invite the Licensure Board Secretaries to meet in January to effect the utmost in achieving reciprocity as regards medical licensure with the other New England States.

This is the type of constructive and progressive action that should be taken by regional groups to solve the problems that have long proved stumbling blocks to individual states. Possibly the forthcoming conference next month will not solve this issue, but certainly it is making a very fine attempt to achieve such a purpose. For the most part, new legislation will not be necessary, but rather by action by the various boards of medical examiners reciprocity could be granted to physicians who meet the equal standards in the other states. If such an arrangement can be effected then there will no longer be a question as to whether medical licensure is a protective mechanism for the establishment of professional guilds or is truly a protection for the public against imposters.

SENSIBLE LEGISLATION

The publication recently by the American Medical Association of the sixth annual summary of Fourth of July injuries due to fireworks and explosions vividly presents anew the importance of sound and sensible legislation for the control of fireworks.

The medical profession had long sounded its complaint against the accident toll resulting from Fourth of July fireworks and explosives, and annually it urged the public to take some action. In 1941 the *Providence Medical News* editorially called attention to the bad Rhode Island record, and as a result of that editorial the press of the state gave the matter wide publicity. Later through the efforts of the Providence Medical Association the problem was clearly presented to leaders in our community and the cooperation of these people did much to focus the attention of the legislature on the Firework Control Law that had been placed before it for several years, but upon which no action had been taken.

In 1942 the measure was finally enacted by the assembly to ban the retail sale of fireworks and their use except by municipalities, fair associations, amusement parks, and other similar organizations, and then only by special police license. Measured in terms of safety and happiness to the citizens of this state the law may well be considered as one of the most important works of the legislature during recent years.

In 1937 the accident toll in Rhode Island included one death, and the yearly record of hospital admissions for Independence Day injuries and burns was becoming progressively worse. For example, in 1941 there were 141 accidents reported by hospitals throughout the state, including five eye injuries, one finger loss, and three fractures. A year later, with prohibitive legislation on the books, a survey conducted by the Providence Medical Association showed only four accidents, all burns or lacerations not of a serious nature, throughout the entire state.

No studies of Fourth of July accidents in Rhode Island had been made since 1942, and therefore the latest survey by the American Medical Association is extremely interesting. It shows that in 1946 this state had but two injuries, both recorded as burns. The City of Providence had no reported accidents or injuries from fireworks, and the City of Pawtucket one of the two injuries reported. This certainly represents a sharp reversal from the safety records prior to 1942.

Thus by sensible legislation adequately enforced we have moved from the category of the state with the worst Fourth of July accident record as judged by the relation between the number of injuries and the size of the population, to the state with one of the finest records in the nation.

STATE HEALTH FEDERATION

When the House of Delegates of the Society meets in January it will be presented with a definite proposal from the Society's committee appointed last spring to study the possibility of an organization of Rhode Island health agencies. The committee has spent much time and has worked actively on the problem during the summer and fall months. That there are operating within the State many health agencies whose primary functions lie in the field of promoting health and preventing disease, and in addition other organizations carrying on combined health and welfare services, that do not correlate and coordinate their activities for the common good, is well known. Some of these agencies concentrate upon selected problems with considerable intensity and thereby become experts in their own field. However, these individual agencies in many instances are financially unable to provide themselves with services, and to undertake studies which would be of benefit to all of them. Therefore, they are unable to give adequate, well-balanced support to the programs and budgets of the official agencies responsible for the health of the community.

As it has been pointed out before, there is no common medium at present, such as a state health council, that could act as a fact-finding organization and through which discussions, continuing analyses of community needs, and unification of function as well as agency stimulation, could take place. Such an organization is necessary if we are to have a continuing and progressively sound health program.

NEW FELLOWS OF THE RHODE ISLAND MEDICAL SOCIETY

Newport:
GEORGE A. ECKERT, M.D., 130 Touro Street
DONALD B. FLETCHER, M.D., Newport Hospital
FRANK J. LOGLER, M.D., Newport Hospital
RICHARD RICE, M.D., Newport Hospital

Pawtucket:
HENRY E. TURNER, M.D., 101 Broadway

Providence:
THOMAS L. O'CONNELL, M.D., 600 Broad Street

Washington County:
JOSEPH L. C. RUISI, M.D., 41 Grove Avenue, Westerly

Woonsocket:
JOHN A. KENNEDY, M.D., 194 Main Street
OSCAR Z. DASHEF, M.D., 202 Stadium Building

AMERICAN PUBLIC HEALTH MEETING

At the 74th annual meeting of the American Public Health Association, held in Cleveland in mid November, the Society was represented by Dr. Francis V. Corrigan and Mr. John E. Farrell. Doctor Corrigan, chief of the division of maternal and child health of the state department of health, served as vice chairman of the APHA's committee on maternal health.

Mr. Farrell, executive secretary of the Society, and a Fellow of the American Public Health Association, presided as chairman of the Eastern regional meeting on health education problems of the states along the eastern seaboard.

Recipient of a Lasker Award for outstanding medical research was the late Dr. Karl Landsteiner, father of Dr. Ernest Landsteiner of the Rhode Island Medical Society. The elder Landsteiner won a Nobel prize in 1930, the Paul Ehrlich medal in the same year, as well as the Dutch Red Cross medal in 1933, because of his discovery of blood groups which made it possible to give blood transfusions safely.

WARNING — MAY BE HABIT FORMING!

A recent opinion from Federal Security Agency, Pure Food and Drug Division, has ruled that Sections 502(d) and 503(b) relative to the marking of prescriptions (WARNING—MAY BE HABIT FORMING) must be carried out to the letter of the law.

Below are the sections of the law so that you may well understand all phases of them:

"(Sec. 502. A drug or device shall be deemed to be misbranded—) (d) If it is for use by man and contains any quantity of the narcotic or hypnotic substance alpha eucaine, barbituric acid, beta- eucaine, bromal, cannabis, carbromal, chloral, coca, cocaine, codeine, heroin, marihuana, morphine, opium, paraldehyde, peyote, or sulphonemethane; or any chemical derivative of such substance, which derivative has been by the Administrator, after investigation, found to be, and by regulations designated as, habit forming; unless its label bears the *name* and *quantity* or *proportion* of such substance or derivative and in juxtaposition therewith the statment "WARNING — MAY BE HABIT FORMING."

"(Sec. 503) (b) A drug dispensed on a written prescription signed by a physician, dentist, or veterinarian (except a drug dispensed in the course of the conduct of a business of dispensing drugs pursuant to diagnosis by mail), shall if—

(1) such physician, dentist, or veterinarian is licensed by law to administer such drug, and

(2) such drug bears a label containing the name and place of business of the dispenser, the serial number and date of such prescription, and the name of such physician, dentist, or veterinarian,

be exempt from the requirements of section 502(b) and (e), and in case such prescription is marked by the writer thereof as not refillable or its refilling is prohibited by law) of section 502(d)."

These two sections are self-explanatory; but to condense them—remember that it is necessary to place upon the container the following: WARNING—MAY BE HABIT FORMING. This inscription is required on the container of every prescription coming within these two sections of the Law, as well as refills. In other words, the only time that a druggist does not put the label of "WARNING—MAY BE HABIT FORMING" on a prescription is when the doctor marks the prescription "Not to be repeated."

Don't forget to check the dates now for the annual meeting of the Rhode Island Medical Society which will be held in Providence on May 14-15, 1947. Mark your calendar to leave these two days free to spend at your medical society sessions.

HOSPITAL ASSOCIATION OF RHODE ISLAND

LEROY P. COX, *President* FRANCIS C. HOUGHTON, *Secretary*
HELEN M. BLAISDELL, R.N., *Vice President* WILLIAM SLEIGHT, *Treasurer*
ARTHUR H. RUGGLES, M.D., *Editor*

NURSING SERVICE AND THE RHODE ISLAND HOSPITAL

OLIVER G. PRATT, *Executive Director*

THE shortage of nurses is presenting a major problem to the Rhode Island Hopsital and to most other hospitals on this continent. A nationwide study by the American Hospital Association in July 1946 demonstrated a need for 120,600 graduate nurses with a potential available of only 37,900 from the army and 35,600 in September graduating classes, leaving a difference of 41,700 nurses short.

This shortage is due to several factors prominent among them being shorter hours, the increase in hospitalization and the ever increasing use of nursing in specialized fields.

The various national nurses associations, the American Hospital Association and the U. S. Public Health Service have worked together on student nurse recruitment and they are today giving consideration to the total problem. The drive for students this past fall fell far short of the goal. There has been confusion as a result of the multiple objectives—of improving personnel practices, educational programs, and student recruitment. The shortage of women for routine ward duties has accentuated the problem.

Industry, public health and government agencies, including the Veterans Administration, all look to hospital nursing schools for qualified graduates.

At the present time the nursing profession is undergoing thorough study. The U. S. Department of Labor is making a comprehensive statistical review. Leaders are reviewing existing practices such as tuition charges, compensation to students, scholarships, government funds, types of schools and various levels of training for those to care for the sick.

The quality of nursing is of primary concern to hospital and nursing associations. They appreciate that the nursing care which patients receive determines in good measure the patient's opinion of the hospital.

The American Nurses Association adopted a platform at their recent convention that includes the following points:

1. Improvement of hours and living conditions for nurses (40 hour week with no salary decrease).
2. Minimum salary adequate to attract qualified nurses, and to maintain standards of living comparable to those of other professions.
3. Work on employment of qualified practical nurses.
4. Greater development of nurses professional organizations as exclusive spokesman for nurses in all questions affecting their employment and economic security.

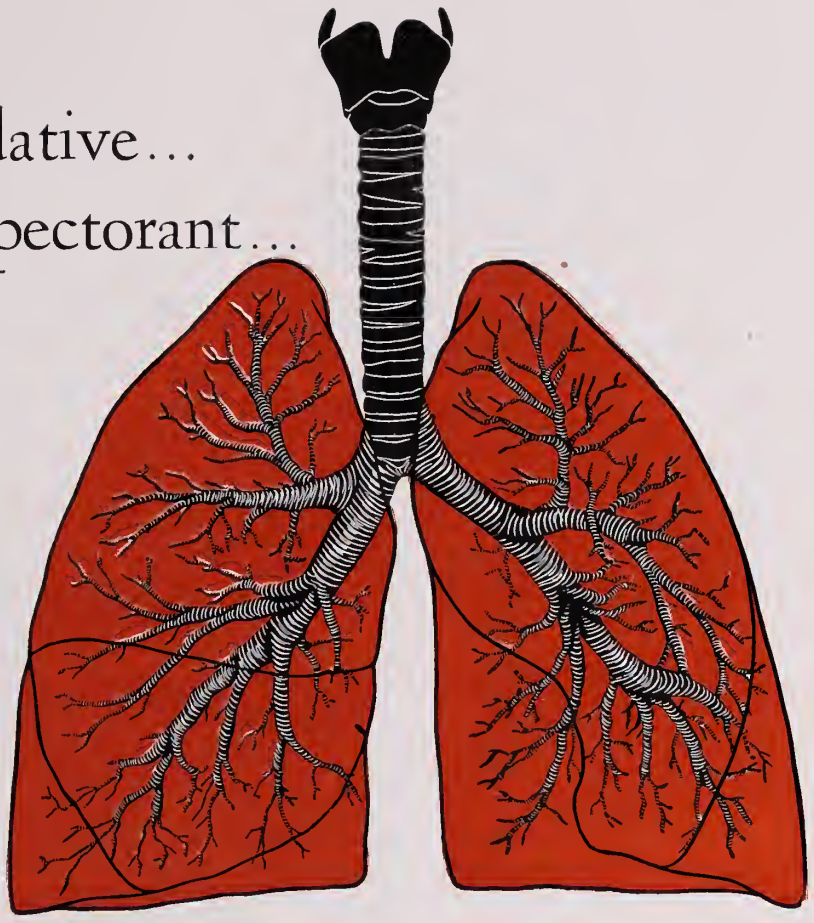
The primary objective of the American Hospital Association is to bring about continued improvement in the quality of hospital service and encouragement of all sound programs aimed at improving the distribution of such hospital care in order that it may be readily available to every citizen of the country.

The American Hospital Association and its affiliated state associations were organized for the purpose of improving hospital service. These organizations have never assumed responsibility for dictating to member hospitals, particularly in matters affecting the internal finances of such hospitals. The Association is firmly of the opinion that the matter of internal relationships between the individual hospital and its personnel is not only primarily each hospital's direct obligation but that over-all leadership and recommendation for the most enlightened attitude for improving these relationships will come, as it has in the past, from the hospitals themselves with whatever advice and counsel as the American Hospital Association and the State Hospital Associations may be able to provide.

The Rhode Island State Nurses Association sent a questionnaire to 3300 nurses—611 answered and of this number:

continued on page 924

bronchial sedative...
bronchial expectorant...



The combined expectorant-sedative action of Lobidine (Searle) leads to amelioration of cough and irritative symptoms accompanying and following upper respiratory infections.

Lobidine
(SEARLE)

Lobidine is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

NURSING SERVICE AND R. I. HOSPITAL

continued from page 922

325 desired an improved salary schedule
152 desired better hours
89 stated nurses should be given more personal consideration
65 desired more adequate rest rooms
55 desired opportunity for further education and training

In an effort to aid in improving nursing service at Rhode Island Hospital the Board of Trustees at a regular meeting on November 6, 1946, voted:

**1. That the Board of Trustees go on record as favoring legislation to license in Rhode Island vocational, practical or attendant nurses and that the necessary steps to aid in the preparation and passage of such legislation be taken.

**2. That the Board of Trustees approve a plan for the development of a corps of paid nurses aides, such a corps to be developed by recruitment of suitable women and giving them a training course of 6 weeks' duration. (Former Red Cross volunteer nurses aides or other women with similar training if employed will not be required to take the course.) The pay schedule for this group is to be in proper relation to other vocations or skills and to include compensation during the training period.

**3. That the Rhode Island Hospital continue to deal with nurses as a professional group. On this basis the Rhode Island Hospital will have a schedule for staff or general duty nurses with one day off one week and a day and one-half the alternate week and with a total cash salary scale beginning at the generally accepted level of $170 per month and increasing on the basis of merit to a maximum of $200 a month. This is to be effective December 1, 1946.

**4. That the Board of Trustees officially support a recruitment drive and approve the principle of financial aid or scholarships as a tool for increasing the number of nurses and improving the quality of nursing service.

5. That the Committee on Nursing of the Board of Trustees be authorized to represent the Board in discussion of these points and any others of a pertinent nature with representatives of the Boards of other hospitals and others interested in and with responsibility for the Public Health.

6. That the Board of Trustees appreciating the value of collaboration among the hospitals of Rhode Island authorize and instruct the administration to send copies of a statement relative to nursing embodying the votes of the Board to:

(a) All hospitals in Rhode Island
(b) The officers of—
1. The Rhode Island Medical Society
2. Rhode Island State Nurses Association
3. The Hospital Association of Rhode Island
(c) and later to the press.

** The Medical Staff Executive Committee of the Rhode Island Hospital on November 4, 1946, approved the principles included in these votes.

RESOLUTION ON HOSPITAL PERSONNEL

(Resolution adopted by the House of Delegates of the *American Hospital Association*, October 2, 1946.

A statement of policy with respect to the relationships between hospitals and employees was passed after revision by a committee appointed during debate. This resolution is as follows:

THE PRIMARY OBJECTIVE of the American Hospital Association is to bring about continued improvement in the quality of hospital service and encouragement of all sound programs aimed at improving the distribution of such hospital care in order that it may be readily available to every citizen of the country.

HOSPITALS serve sick humanity. In the alleviation of suffering, the highest type of personal service is demanded. Hospitals, in the interest of the best service for the people of this country, should and must carry on many educational processes and stimulate research. Further, hospitals have an important part to play in public health and in health education. Hospitals function as a workshop for the physician, nurse and many other skilled professional workers and technicians. Proper care for the sick requires the utmost cooperation among these groups if the patient is not to suffer unduly. This places heavy responsibilities on hospital personnel. Yet those who serve the sick have opportunities for service and satisfaction beyond those available to any other of the employed groups.

IN ALL MATTERS the administration of hospitals stands as the representative of the general public. With due realization of the economic rights of those who serve in hospitals, the administration, in planning the economics of the hospital, must bear in mind not only the quality of service and rights of employees, but also the burden thus placed upon those who must meet the cost of hospital care which is such a vital necessity in time of illness.

continued on page 926

why Dexedrine is so beneficial in menstrual dysfunction









"The Central Nervous Stimulant of Choice"

Dexedrine therapy not only alleviates the mental depression and psychogenic fatigue which ordinarily accompany dysmenorrhea; but also, through its marked amelioration of mood, beneficially alters the patient's reaction to pain.
Smith, Kline & French Laboratories, Philadelphia, Pa.

Dexedrine Sulfate tablets

(dextro-amphetamine sulfate, S.K.F.)

RESOLUTION ON HOSPITAL PERSONNEL

continued from page 924

THE AMERICAN HOSPITAL ASSOCIATION endorses the best possible working conditions for all hospital personnel and realizes the demanding service required of those who serve patients. Much has been done to improve conditions for hospital personnel. The administration of all hospitals, too, must bear in mind its dual responsibility toward those rendering hospital care and those who receive such care.

THE AMERICAN HOSPITAL ASSOCIATION and its affiliated state associations were organized for the purpose of improving hospital service. These associations have never assumed responsibility for dictating to member hospitals, particularly effecting the internal finances of such hospitals. The Association is firmly of the opinion that the matter of internal relationships between the individual hospital and its personnel is not only primarily each hospital's direct obligation but that over-all leadership and recommendation for the most enlightened attitude for improving these relationships will come, as it has in the past, from the hospitals themselves with whatever advice and counsel as the American Hospital Association and the State Hospital Associations may be able to provide.

PLATFORM FOR AMERICAN NURSING ASSOCIATION

(Reprinted from American Journal of Nursing, November, 1946)

1. Improvement in hours and living conditions for nurses, so that they may live a normal personal and professional life, specifically, action toward

   a. wider acceptance of the 40-hour week with no decrease of salary, thus applying to our post-war conditions the principle of the 8-hour day adopted by the American Nurses' Association in 1934;

   b. minimum salaries adequate to attract and hold nurses of quality, and to enable them to maintain standards of living comparable with other professions.

2. Provision for optimal nursing care for all, and furtherance of a positive health program in all communities.

3. Increased participation by nurses in the actual planning and in the administration of nursing service, in hospitals and other types of employment.

4. Greater development of nurses' professional associations as exclusive spokesmen for nurses in all questions affecting their employment and economic security. Such a development should be based on past successful experience of professional nurses' organizations in collective bargaining and negotiations.

5. Removal, as rapidly as possible, of barriers that prevent the full employment and professional development of nurses belonging to minority racial groups.

6. Employment of well-qualified practical nurses and other auxiliary workers under state licensure, thus protecting both the patient and the worker.

7. Continuing improvement in the counseling and placement of nurses, to give greater stability and job satisfaction to the profession and to facilitate a better distribution of nursing service to the public.

8. Further development of nursing in prepayment health and medical care plans, in order to spread the cost of nursing service to the public.

9. Maintenance of educational standards, and development of educational resources, that nursing may keep abreast of the rapid advances in medicine and other sciences. Such development may well require federal subsidies; and contributions from foundations and other educational philanthropies.

10. Appraisals of our own national organizations, through the report of the Structure Study, and fearless action based upon such appraisal, to make sure that the nursing profession will be organized and equipped to deal most effectively with its problems and its opportunities.

NEW ENGLAND ALLOTMENTS

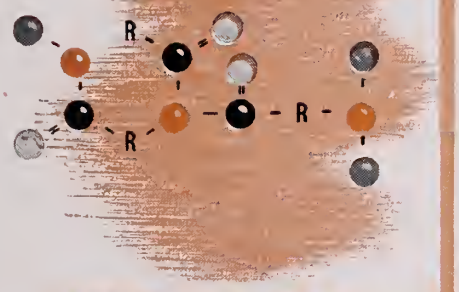
The allotments to the states, on a population basis, of funds for survey and planning and for construction of hospitals under the Hill-Burton Act passed by the 79th Congress shows the following distribution to the New England states:

State	*Allotments*	
	Survey and Planning	Construction
	$3,000,000	$75,000,000
Connecticut	$ 40,474	$ 421,950
Maine	17,671	454,875
Massachusetts	93,515	1,595,550
New Hampshire	10,207	342,375
Rhode Island	15,989	280,275
Vermont	10,000	214,725

The American College of Physicians has announced that its 28th Annual Session will be held in Chicago, April 28 through May 2, 1947. For detailed information communications should be addressed to the Executive Secretary of the College at 4200 Pine Street, Philadelphia 4.

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Completely adaptable to any type of diet
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ESSENAMINE is pure, concentrated protein of high biologic value — partially hydrolyzed to facilitate utilization .. Contains no added carbohydrates — no flavoring matter — has no unpleasant taste to be disguised. Derived from lactalbumin, Essenamine is a rich source of all the essential amino acids.

ESSENAMINE is compatible with any food that appeals to capricious appetites ... large amounts may be easily and tastily administered in hot or cold beverages, custards, cookies, bread and muffins, soups, candies, cereals, puddings, meat loafs, et cetera.* Essenamine is not destroyed by cooking.



INDICATED as a supplement to the diet, or as the sole source of nitrogen, to correct or prevent protein deficiency states.

*An attractive, practical recipe booklet — of special interest to dieticians — will be sent to physicians, nurses and dieticians on request.

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CLINICOPATHOLOGICAL CONFERENCE

Rhode Island Hospital

Age: 77; male

Occupation: "Retired"

Chief Complaint:

Chest pain and prostration.

Present Illness:

On the day of admission this man suffered a sudden severe chest pain, "mostly on the left" which he vaguely admitted went to the left shoulder. There was no history of previous anginal pain or cardiac decompensation. He was admitted at 10:00 P. M. and was said to have voided no urine since late in the forenoon.

Physical Examination:

Patient described as pulseless, extremely cold and cyanotic. Heart rate 102; rhythm regular; sounds of "poor quality". *Lungs:* A few moist rales at posterior left base. *Abdomen:* No masses felt. No evidence of bladder distension. *Extremities:* No edema.

Course in Hospital:

A tentative diagnosis of acute myocardial infarction was made.

Treatment included oxygen by oropharyngeal insufflation, 250 cc. of plasma intravenously and morphine sulphate grain 1/6 hypodermically.

Attempts to catheterize him were unsuccessful until the next day when about 30 cc. of urine were obtained.

He remained in shock until eighteen hours after admission. That evening his blood pressure was 116/72 but he had passed practically no urine.

On the third hospital day an output of 300 cc. was obtained and none thereafter. Temperature varied between 100 and 101 and pulse between 88 and 110 per minute. Examination on the third hospital day showed him dull with good color, coughing and raising purulent sputum. Lungs showed bilateral basal rales and abdomen was markedly distended with only occasional distant peristalsis audible. Heart rate about 100. Blood pressure 105/65, later 136/86. No edema. Fairly good dorsalis pedis pulsations. He was given 500 cc. of plasma and later 1,000 cc. of 10% dextrose in water. During this infusion he went into an attack of acute pulmonary edema and was treated with oxygen and tourniquets to the extremities with improvement. An x-ray of chest was taken before this episode.

On the evening of the third hospital day the blood pressure was recorded as follows: 5:30 P. M. 140/70; 11:00 P. M. 130/72. Pulse at apex 92. During the next hour he became restless, respirations became labored and blood pressure at midnight was 86/60. At 2:00 A. M. blood pressure 66/44; pulse 126; respirations 32. He was treated with 250 cc. of plasma at 2:00 A. M. and again at 3:15 A. M. Coramine was also given. Cheyne-Stokes respirations were noted at 3:50 A. M. and at 4:10 respirations ceased.

After his death a vague history of his having been "struck and spun around" but not knocked down while helping in the removal of a stump.

Laboratory Work:

Second Hospital Day: Urea nitrogen 52 milligrams; Glucose 115 milligrams; Creatinine 4.7 milligrams; Hinton negative.

Third Hospital Day: Urea nitrogen 56 milligrams; Creatinine 5.7 milligrams; chlorides 304; Sodium chloride 500; Carbon dioxide combining power 43 volume %. Urine: Straw colored; Specific gravity 1.010; Reaction acid; Protein 1+; Sugar negative. Sediment: 10 leucocytes per high power field and a few coarsely granular casts.

X-Ray—March 29, 1946:

Chest: Relations of the mediastinum and heart are distorted on account of patient's rotation. Both lungs show fine infiltration throughout the distribution increasing in prominence towards the base where the shadows are somewhat patchy. On the left side the diaphragm is not seen clearly. Right diaphragm is sharp. Aortic arch is tortuous and prominent. The cardiac outline seems somewhat enlarged. Appearances in both lungs are suggestive of vascular congestion and scattered pulmonary edema. Question of slight pleural effusion at the left base. The possibility of bilateral bronchopneumonia cannot be excluded. Urinary tracts: No definite urinary calculi seen. Both kidney outlines not seen clearly on account of haziness of upper abdomen. Moderate amount of gas scattered throughout colon to lower sigmoid. Several

continued on page 930

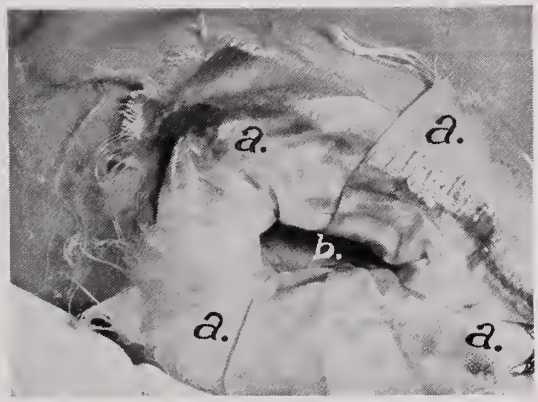
Fiberglas Cloth Used Experimentally For Postoperative Wound Dressings

Fiberglas materials have been shown to be uniquely suited to certain medical uses through their experimental application by physicians, surgeons and others engaged in medical research.

The quest for an ideal packing material for postoperative care of compound wounds, for example, was based upon a number of qualifications.

ESSENTIAL FACTORS

Such an improved dressing must allow proper drainage and granulation of the wound so that an early split-skin graft can be applied if desired. It should be non-irritating to the skin and should not act as a foreign body if left embedded in human tissues. It should prevent adherence of granulations and prevent exuberant granulation. It should not cause pain or excessive bleeding on removal, and should be simple to prepare and use.



United States Army Signal Corps Photo.

Shoulder wound, three weeks after saucerization of the cavity. (a) Fiberglas Cloth may be seen on the wound surfaces. (b) No granulations are growing through the meshes.

After consideration of these factors, Fiberglas Cloth was tried experimentally at the Percy Jones General Hospital, Battle Creek, Mich., in thirty-five cases where ordinarily petrolatum-impregnated gauze would have been used.

METHOD OF APPLICATION

In applying the dressing at the time of surgery, a square of glass cloth is cut large enough to cover all surfaces of the wound and to project over the skin margin. The center of the invaginated glass cloth should be packed with dry cotton gauze to hold open the edges of the wound and to act as a wick to remove exudate. A pressure bandage or padded cast, as indicated, is placed over such a dressing.

These Fiberglas dressings were left in the wound for varying periods of time. The report in the *Journal of Bone and Joint Surgery** says, "contra-indications have not been observed". Fiberglas Cloth was also tried as the first layer of a wet dressing for a split-skin graft. By such experimentation, the uses of Fiberglas in medicine are being established.



United States Army Signal Corps Photo.

The same wound (a) after removal of Fiberglas Cloth, showing clean granulations and no bleeding or thick exudate.

Fiberglas is the trade name of a variety of products made of glass fibers. Glass textile fibers, made in diameters from two to four ten-thousandths of an inch are formed into yarns which are woven into a wide variety of textiles.

Fiberglas is an inorganic, non-toxic, non-allergenic, non-sensitizing and chemically-stable material that produces no harmful effect upon human tissue. These fine fibers are pliable and possess great tensile strength. They have dimensional stability, are unaffected by temperature extremes, corrosive fumes and most acids. They are non-hygroscopic and non-combustible, and may be easily sterilized and resterilized. In a special glass formula, they are radiopaque.

*Vol. 28, No. 1, pp. 180-181, January, 1946.

Some Other Uses of Fiberglas in Medicine

For some time, it has been the policy of Owens-Corning Fiberglas Corporation to supply samples of Fiberglas in any available form to qualified persons engaged in research. Write Owens-Corning Fiberglas Corporation, 2036 Nicholas Bldg., Toledo 1, Ohio.



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FIBERGLAS
T.M. REG. U.S. PAT. OFF.

CLINICOPATHOLOGICAL CONFERENCE
continued from page 928

loops of distended small intestine in the mid-abdomen. Appearances not characteristic of obstructive ileus. Multiple phleboliths on both sides of the pelvic cavity. Sickle shaped calcifications seen projected over upper portion of the right sacral wing possibly a sclerotic process in the bone itself.

Electrocardiogram: March 28, 1946

The tracing shows a normal sinus rhythm. The P-R interval is normal. There is minimal elevation of the ST interval in the third lead. The T waves are normal throughout as are the chest leads. The tracing shows no diagnostic abnormality. Rate 92.

Clinical Discussion: Dr. Robert G. Murphy

In summary this elderly man's illness was characterized by dramatic onset with thoracic pain, circulatory collapse and shock which improved some with treatment. An interesting feature was the most complete anuria which may be an important clue to the diagnosis. On the eventful fatal third hospital day in the evening, another phase commenced with dyspnea, restlessness, falling blood pressure and death four hours after the beginning of this change. I would like to call attention to the history of trauma which was obtained after his death. I believe that this was about five days before the onset of this fatal illness.

Laboratory work showed increasing nitrogen retention and abnormal urinalysis. One would like to know the white count and particularly the red count or hemoglobin as it is suspected there was a significant degree of anemia. The x-rays are helpful as the relation of the mediastinum and heart are distorted. The aortic arch was tortuous and prominent and the cardiac outlines seemed somewhat enlarged. The lungs showed vascular congestion and scattered pulmonary edema. There was a question of slight pleural effusion at the left base.

An x-ray of the abdomen showed distended loops of small intestine which were probably paralytic ileus as they were said not to be characteristic of obstructive ileus. The electrocardiogram is interesting chiefly because it was not characteristic of myocardial infarction, pericarditis or pulmonary embolism. Wtih the history of severe chest pain followed by shock and circulatory collapse one quite naturally considers the diagnosis of acute myocardial infarction. However, there is nothing further to support this diagnosis such as characteristic electrocardiograms, precordial friction rub or past history of angina.

It is said that the following conditions are often misdiagnosed as myocardial infarction: Penetrating peptic ulcer, acute cholecystitis, acute pancreatitis, laceration or perforation of the esophagus, mediastinitis, pericarditis, pleuritis, spontaneous pneumothorax and pulmonary embolism or thrombosis. I think that these conditions can be ruled out for one reason or another by the lack of characteristic physical signs, x-rays, electrocardiograms or clinical course. Probably the most difficult to rule out is pulmonary embolus or thrombosis as the x-ray of the chest was abnormal but did not show typical pulmonary infection. However, there was no hemoptysis, pleural friction rub, characteristic electrocardiographic findings or a known site from which the embolus might originate, such as thrombophlebitis.

In the differential diagnosis we then come to a consideration of aneurysm of the aorta. The Hinton was negative. There were no previous signs or symptoms of a saccular or fusiform arteriosclerotic or syphylitic aneurysm. This type of aneurysm is not shown in the x-rays we have of the chest and abdomen. I would expect that if this type of saccular fusiform aneurysm ruptured that the fatal terminus would occur more quickly and would not have a clinical course of three days. Therefore, I believe that the dissecting aneurysm of the aorta best explains the signs, symptoms, laboratory, x-ray findings and clinical course. For this condition to occur the first requisite is arteriosclerosis of the aorta. I think we have good evidence for this. Weakening of the wall occurs because of sclerosis of the vas vasorum of the media. The second requisite is the existence of increased tension within the aorta. This may have been supplied by a previously unrecognized hypertension or by the trauma mentioned in the history. Often these progress in two stages: The first is due to the initial tear in the intima and the dissecting blood column proceeds proximally toward the heart or distally down the aorta toward the bifurcation. The most common sites for this tear in the intima are in the aortic arch either just above the valve or at the attachment of the ligamentum arteriosum. This first stage is often attended by chest pain, collapse, cyanosis, pulmonary edema, congestion, and bronchopneumonia. Pleural effusion commonly occurs on the left side but may be first serous and later hemorrhagic. As the dissection proceeds down the aorta, small blood vessels are cut across and larger ones are closed by the hemorrhage invading the wall of the arteries. If the mesenteric arteries are involved, paralytic ileus often occurs.

There is often also evidence of kidney disease as was present in this case and may be due to antecedent kidney disease or to dissection and blocking of the renal arteries. If the carotids are invaded there are cerebral symptoms which were not present in this case and if the iliac arteries are invaded

there is usually pain in the legs, absent pulsation in the arteries and temperature and color changes in the extremities. Encroachment on the ostia of the coronary arteries may give electrocardiographic changes characteristic of acute myocardial infarction. This also did not occur. If a second rupture occurs back in the lumen of the aorta, this condition is not incompatible with life and results in a so-called double-barreled aorta. The second stage which could be represented by this patient's sudden change on the third hospital day occurs when the second rupture occurs into the mediastinum, pericordium, pleural cavity or retroperitoneally.

Pathological Diagnosis:

Saccular aneurysm of abdominal aorta, with rupture.

Massive retroperitoneal hemorrhage.

Hemoperitoneum.

Discussion of Pathology:

DR. ROBERT J. WILLIAMS

The essential anatomical findings were limited to the abdomen. When the peritoneal cavity was opened there were 300 cc. of fluid and clotted blood present. The retroperitoneal spaces on both sides of the vertebral column throughout the entire length of the abdomen were distended by a massive amount of fluid blood and currant jelly blood clot. The origin of this hemorrhage was a saccular aneurysm of the lower abdominal aorta which had ruptured. This is a different type from the dissecting aneurysm of which Doctor Murphy spoke. It was located in the abdominal aorta just above its bifurcation. It presented itself in a saccular form 8.5 cm. in diameter. A brownish-red adherent blood clot partially filled the sac, but did not occlude the lumen of the aorta. It had a laminated appearance on its cut surface. There were three ragged defects in the posterior wall of the aneurysm which communicated with the retroperitoneal space. The aneurysm was localized and there was no dissection of the wall of the aorta. There was present a large amount of arteriosclerosis of the aorta, which would account for the development of the aneurysm.

The clinical story indicates that the leakage of blood into the retroperitoneal space occurred over a period of at least several days.

There were no other significant pathological findings.

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THE PATHOLOGICAL INSTITUTE AND THE COST OF MEDICAL CARE

JOHN F. KENNEY, M.D., F.A.C.P.

The Author. *John F. Kenney, M.D., F.A.C.P., of Pawtucket, R. I. Diplomate, Board of Internal Medicine; Consultant to Rhode Island hospitals; Past President, Rhode Island Medical Society.*

I WILL attempt in this paper to bring out two points. First, that a pathological institute in either a small or a large community makes for more efficient diagnosis and, therefor, better medical care. Secondly, if properly and efficiently used, it will act in lowering the cost of medical care and supply a need that many of the plans, both government (state medicine) and medical society, that are advanced over different sections of the country do not cover.

Briefly, what is a pathological institute? It is a center set up in a locality most convenient to the larger hospitals and is either underwritten by a group of private individuals or philanthropists, or a foundation, or underwritten by the government or state, or run by the medical profession and member hospitals utilizing the already existing facilities. (This latter is our R. I. Pathological Institute set-up.) It may even be located in one of the larger hospitals in the community as a temporary means until such buildings and proper facilities have been established.

We have our pathological institute already established in the largest hospital in the state and it has started with four member hospitals. Contrary to the belief that it is only to the advantage of the smaller hospitals, the larger hospitals benefit as well. Combined this way, the group can necessarily afford a more efficient, higher paid personnel, with each member hospital contributing to its support, and, therefore, the larger hospitals are able to employ better personnel than if working alone. It is a distinct advantage for small hospitals that may have inefficient personnel and to them is made available expert advice in the fields of pathology, bacteriology and chemistry by experts when ordinarily they would have no laboratory facilities at all or would be under the direction of one man who is often underpaid trying to cover all of the above fields.

The parent institute sends out to each member hospital by rotation the various trained experts in the different fields so that some one of these experts is on hand in a member hospital. The pathological institute eventually training residents who will be farmed out to the member hospitals and brought back repeatedly for training, is also an advantage to both the larger and the smaller hospitals. Again, all the technicians working in the member hospitals are called to the parent institute by rotation for several months at a time, their places in the hospitals being taken by technicians sent out by the main institute or laboratory.

The best argument in view of all this is that surgery and medical conditions are the same for the person in the small community as well as in the large, and treatment, whether medical or surgical, is so often based on accurate diagnosis. Therefor, the patient in the small area is entitled to the same procedures as in the larger areas, and should not have to be sent to a large center to have either medical or surgical treatment and particular diagnosis when it can be carried out in his own area.

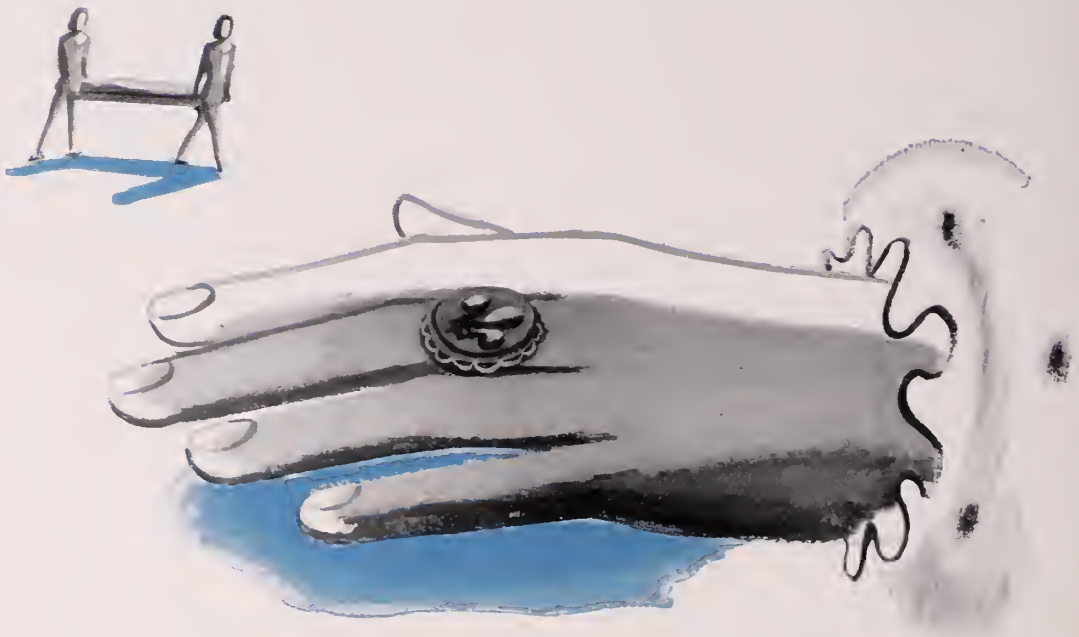
Coming to the second advantage—that is lowering of the cost of care—many patients are sent to hospitals for diagnosis using up the beds, particularly in these times, that are badly needed for all kinds of medical and surgical treatment. Patients not able to afford rooms have been sent to the wards thus overcrowding. The physician feels that the cost to the patient for laboratory work may be beyond his means or that the physician does not have the equipment in his office, the technical help or space to do it personally. We have commercial laboratories but the cost of the individual test in some cases for diagnosis amounts to a large sum, frequently equalling the cost of the treatment and the physician hesitates to ask the patient to assume this cost, hence the hospital. If I might cite one example, a case of suspected pernicious anemia, presents herself to a physician's office. If the diagnosis could be definitely made such a case could be treated without any hospitalization, but it often requires complete blood work, stomach contents, blood volume, etc., that the physician is not prepared to carry out in his office. If each physician

continued on page 956

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DISTRICT SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A MEETNG of the Newport Medical Society was held on Tuesday evening, October 29, 1946, at the Newport hospital.

The meeting was called to order at 8:52 p. m., with Dr. Alfred M. Tartaglino presiding, and the following Doctors in attendance: Tartaglino, Young, Bestoso, Stoops, Ciarla, Zielinski, Tollefson, Grimes, Jerech, Adelson, Ramos, Mayner, Malone, Abramson, and Brownell.

The minutes of the June meeting were read and approved.

There was no unfinished business or communications.

The applications for membership for Drs. Frank Logler, George Eckert, Donald Fletcher, Edward Zamil, and Richard Rice, which had been passed by the censors, were presented and the five were elected.

Following the election, there was some discussion as to the by-laws of the Society which state that the physician should be in active practice in the county for a period of one year prior to applying for membership in the Society. It was pointed out that the rule had been waived by common consent over a considerable period of years, and that adherence to the rule would work considerable hardship on a physician, since membership in the Society was tantamount to hospital privileges at the Newport Hospital. It seemed generally agreed that the rule should not be invoked but that physicians should be in actual practice in the county before submission of application to the Society.

The speaker of the evening, Dr. Clifton B. Leech, of Providence, was then presented, and in a very enlightening and complete discourse covered most of the important advances in the treatment of cardiovascular renal disease of the past decade.

Following a period of questions and answers the meeting adjourned at 10:35 p. m. A collation was served.

HENRY W. BROWNELL, M.D., *Secretary*

WOONSOCKET MEDICAL SOCIETY

A meeting of the Woonsocket District Medical Society was held at the Club Canadian on Tuesday, November 12, 1946. The meeting was called to order at 9:30 p. m. by President Joseph Reilly.

The main discussion of the meeting was that of group disability insurance as presented by a representative of the Commercial Casualty Insurance Company.

The secretary presented the applications for active membership in the Society of the following physicians: Oscar Z. Dashef, M.D., 202 Stadium Building; John A. Kennedy, M.D., 194 Main Street; Elphege Beaudreault, 441 South Main Street.

It was moved that these applicants be elected to membership. The motion was seconded and unanimously adopted.

A collation was served after which the meeting adjourned at 12:10 p. m.

ALFRED E. KING, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 4, 1946. The meeting was called to order at 8:30 p. m. by President Paul C. Cook.

The reading of the minutes of the previous meeting was omitted by approval of the members present.

The Secretary read a communication from the Providence Chapter of the Red Cross as follows:

"According to reports a somewhat serious epidemic of influenza is anticipated this winter. In view of the shortages of doctors, nurses and hospital beds, the importance of the free Red Cross courses in Home Nursing is greater than ever.

"An aftermath of the war seems to be evidenced in public apathy toward volunteering or participating in free class instruction. The Red Cross teaches home nursing by means of a streamlined, 6 2-hour lesson course on—

1. What to do when sickness occurs
2. How to make the patient comfortable in bed
3. How to keep the patient clean and well groomed
4. How to give food and medicine that have been ordered for the sick in the home

continued on next page

5. How to give simple treatments ordered by the doctor
6. How everyday skill in the care of the sick helps to control the spread of communicable diseases.

"It has been suggested that one effectual way of arousing public interest in availing themselves of this offer is to bring the matter to the attention of the medical men of our community, who in turn may urge their patients to enroll as Home Nursing students. By so doing, they will be helping to relieve the strain under which so many are working and also will be insuring more intelligent care of patients, particularly at the onset of illness when proper early care may be the means of avoiding more serious complications."

The secretary also read a communication from Grace Church in Providence extending invitation to the physicians of the Association to attend the morning service on November 17 at which Edward H. Hume, M.D., is to speak.

Dr. Paul C. Cook announced that the public service engineer of the City of Providence had requested that the Association appoint a committee to meet with him to discuss the automobile parking situation in the Waterman-Angell Street area. Dr. Cook announced the appointment of the following committee for this assignment: Dr. Clifton B. Leech, Chairman; Dr. Elihu S. Wing, Dr. A. A. Savastano, Dr. Frank W. Dimmitt and Dr. Robert G. Murphy.

Dr. Cook briefly discussed the great significance of the atomic bomb, and its possible effect upon medical procedures in the future. He then introduced Dr. Shields Warren, Pathologist at the New England Deaconess Hospital, who was one of the physicians who participated in the medical research of the atomic bombing in Japan, and was also one of the observers of the post-war atomic tests in the Pacific. Dr. Warren discussed "Medical Aspects of Atomic Bombings" illustrating his lecture with lantern slides of scenes taken at the sites of the bombings.

In summarizing what is known about the subject to date, Dr. Warren pointed out that the products of atomic fission are, as yet, of little practical use in the treatment of disease. However, radioactive isotopes, which are by-products of atomic fission, are useful as tracer substances in clinical investigation. For example, by the use of radioactive phosphorous, this element can be detected in amounts approximating 10-14 grams. Another clinical problem that has been investigated by this means is the question of insulin resistance. By using tracer zinc combined with insulin, it has been demonstrated that many instances of insulin resistance are due to poor absorbtion from the site of injection associated with local fibrous tissue. In discussing the atomic bomb, Dr. Warren pointed out that in addition to the explosive force evident with other types of bombs, there is thermal radiation and ionizing radiation which are produced.

The speaker described his experiences in Japan and at Bikini and illustrated many of the points by lantern slides. The thermal burns produced by the bombs are characterized by extremely sharp lines of demarcation. In the use of nuclear energy, the residual radioactivity in objects that are exposed to the radiation, poses a real problem.

Following his presentation Doctor Warren answered many questions directed to him from the audience.

The meeting adjourned at 10:20 p. m. Attendance—140. Collation was served.

FRANK B. CUTTS, M.D., *Secretary*

R. I. Regional Committee on Fractures and Other Traumas —American College of Surgeons—

The meeting of the Rhode Island Regional Committee on Fractures and Other Trauma was held at the Medical Library, Francis Street, Providence, R. I., on November 18, 1946. It was called to order by the Chairman, Dr. Henry McCusker at 8:40 P. M.

Dr. McCusker expalined briefly the aims and object of the Regional Committee, stating that it was mainly educational in regard to the proper care and treatment of fractures and particularly applicable to the smaller hospital groups.

He then outlined the requirements and suggestions of the National Committee in respect to meeting, reports and sub-committees. After a general discussion the following committees were appointed.

1—*Membership Committee*
Dr. Robert T. Henry, *Chairman*
Dr. William A. Horan
Dr. Henry McCusker

2—*Committee on Clinical Meetings*
Dr. Louis Sage, *Chairman*
Dr. James C. Callahan
Dr. Walter J. Maloney
Dr. Armand A. Bertini
Dr. James R. McKendry

3—*Committee on Hospital Care and Equipment*
Dr. John Paul Jones, *Chairman*
Dr. Augustine Eddy
Dr. S. G. Lensner
Dr. S. S. Farago

4—*Committee on Relations with Other Organizations*
Dr. Peter Pineo Chase, *Chairman*
Dr. Kenneth Burton
Dr. Arthur Martin
Dr. William A. Stoops

continued on page 940

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REGIONAL FRACTURE COMMITTEE MEETING

concluded from page 938

5—*Committee to Consider the Advisability on Assembling Syllabus for Accident Room Treatment of Fractures*

Dr. Ernest D. Thompson, *Chairman*
Dr. William V. Hindle
Dr. John H. Gordon

Delegates to the fracture section at the Cleveland meeting of the American College of Surgeons December 16-20, 1946: Dr. James R. McKendry, Dr. Robert T. Henry.

Dr. Carroll M. Silver was commissioned to review Key and Conwell's latest revision of "Fractures, Dislocations and Sprains" for Dr. Chase; the same to be published in the book review in the R. I. Medical Journal.

Attendance — Drs. Chase, Gordon, Henry, Hindle, Horan, McCusker, McGovern, McKendry, Sage, Silver, Thompson.

Robert T. Henry, M.D., *Secretary*

R. I. Chapter, Gastroenterological Association

The Rhode Island Chapter of the Gastroenterological Association had the quarterly meeting at the Hope Club on November 6th, 1946 at 6:30 P. M.

Dinner was served and following this the chapter was addressed by Dr. William Reid Morrison, Surgeon-in-Chief of the Boston City Hospital, on the subject entitled "Double Vagotomy for Intractable Ulcer". This paper was discussed by Dr. McClure, gastroenterologist at the Boston City Hospital, and Dr. Frank Cummings of Providence, Rhode Island. Dr. Tage Christiansen, chairman of the Gastroenterological Society of Copenhagen, Denmark and delegate of the Danish Ministry of War to the United States, then addressed the chapter telling about the plight of the people of northern Europe in general and of the medical profession in particular. Dr. Jesse P. Eddy, III, presented a case of total gastrectomy and subtotal transverse colectomy for an acute perforated malignant ulcer in a carcinomatous stomach, linitus plastica in type. Careful search of the literature had failed to reveal a similar case having been reported in the past. Approximately one hundred subtotal gastrectomies have been done for acute perforated ulcer, but no case of total gastrectomy has been found to date.

Following remarks for the good of the chapter, the meeting was adjourned.

Jesse P. Eddy, III, M.D., *Secretary*



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Richards, R. K., and Perlstein, M. A. (1945), Tridione, a New Experimental Drug for the Treatment of Convulsive and Related Disorders, Proc. Chicago Neurological Soc., Jan. 9; and (1946), Arch. Neurol. and Psychiatry, 55:164, February.

Lennox, W. G. (1945), Petit Mal Epilepsies: Their Treatment with Tridione, J. Amer. Med. Assn., 129:1069, December 15.

DeJong, R. N. (1946), Effect of Tridione in the Control of Psychomotor Attacks, J. Amer. Med. Assn., 130:565, March 2.

Thorne, Frederick C. (1945), The Anticonvulsant Action of Tridione, Psychiatric Quarterly, October.

Erickson, T. C., Masten, M. G., and Gilson, W. E. (1946), Observations on the Use of Tridione in the Treatment of Epilepsy, Presented before Amer. Neurological Soc., San Francisco, June.

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1. McGavack, T. H.: J. Clin. Endocrinol. 3:71, 1943.

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MEDICAL CARE THROUGH PREPAID INSURANCE

In submitting this report to the Council of the New England State Medical Societies the subcommittee has relied on information submitted to it by representatives in the various states. The progress of medical care plans sponsored by the state medical societies is summarized by states as follows:

Massachusetts

Massachusetts Medical Service, a non-stock corporation, came into being on June 2, 1942, under an enabling act approved May 22, 1941, with twenty-three physicians as incorporators.

General administration of the Act is delegated to the Commissioner of Insurance who must approve in writing all subscription agreements, participating physician agreements, subscription rates and schedules of fees. He may also limit acquisition and administration costs and require that a special contingent surplus be accumulated and maintained. Massachusetts Medical Service was required to set aside 25 per cent of its monthly subscriber income until a surplus of $225,000 had been accumulated, and this was done. Its acquisition and administration costs have never been limited.

The majority of the board of directors must be persons approved in writing by the Massachusetts Medical Society. Any registered physician has the right to participate provided he is willing to abide by such rules and regulations as the corporation makes.

As a charitable corporation Massachusetts Medical Service is exempt from all state and local taxes. However, because the budget of the commissioner of insurance did not provide funds for him to exercise properly the responsibilities delegated to him by the Act, the proponents of the bill agreed to a 1 per cent tax on subscriber income. For the year 1945 the Corporation returned approximately $10,000, which sum would appear to be somewhat in excess of the costs incurred by the Department of Insurance in supervising the activities.

Although the enabling act provides that a majority of the Directors must be approved by the Massachusetts Medical Society, it has been the practice for the Society to nominate all fifteen of the non-salaried directors, one-third of whom must be licensed physicians.

Membership: Two classes of members—unlimited and limited—are designated. An unlimited (under-income) member is any subscriber without dependent members whose total annual income is $2,000 or less, or any one of a family group the total annual income of which is $2,500 or less. A limited (over-income) member is one whose annual income exceeds these respective amounts. Annual income is defined as the total income from all sources during the twelve-month period immediately preceding application for benefits and it has been construed to include other than cash income.

Services: The unlimited (under-income) member is entitled to "service benefits", which means that for services rendered under the terms of the subscriber certificate a participating physician accepts direct payment from the Corporation as full discharge of the obligation. The limited (over-income) member is entitled to "indemnity benefits", meaning that although the Corporation extends its usual payment to the participating physician, he is not barred from making an additional charge, which is a private matter between the member and the participating physician and in no way involves the Corporation.

To be eligible for medical services, which are services of a general medical nature, a member must be a hospitalized bed patient. Surgical services encompassing all generally accepted surgical procedures are available both in and out of the hospital during twenty-one days per illness or injury. Obstetrical services, available either in or out of the hospital during twenty-one days per agreement year, are normal or abnormal delivery of a live or dead fetus of seven or more months' gestation, prepartum and postpartum care during confinement, treatment of toxemia of pregnancy and routine care of a full-term or premature new born. Accidents of pregnancy which accrue prior to the seventh month of gestation are covered by surgical services.

Anesthesia services are provided when they are directly related to medical, surgical or obstetrical services furnished by the Corporation. The allowance for diagnostic x-ray is $15 per illness or injury.

Relations with Blue Cross: By agreement the Blue Cross undertakes to (1) furnish office space

continued on next page

MEDICAL CARE THROUGH PREPAID INSURANCE

continued from previous page

for personnel serving both corporations; (2) supply services necessary for the acquisition of subscribers; (3) provide all administrative services, including billing, accounting and general operating supervision; (4) render bills on all outstanding Blue Shield memberships and use its best efforts to collect all such accounts receivable; (5) use efforts in the acquisition of subscribers to Blue Shield similar in kind and degree to and consistent with its own acquisition policy, and consult with Blue Shield with respect to general program and detail.

Enrollment: Total enrollment at the end of 1943, the first year of operation, was 21,188 members. At the end of 1944 the figure was 69,874; at the end of 1945, 206,729. By the middle of 1946 there were 300,000 members and additions were being made at the rate of 20,000 a month.

Financial experience: Operations were begun in February of 1942 with a loan of $25,000 from the Massachusetts Medical Society. The Corporation has never been in financial difficulty and its surplus at the end of three and a half years of operation was almost $600,000.

New Hampshire

The New Hampshire Physicians Service, according to all reports, continues to operate most successfully. The plan supplies broader coverage than is attempted by most medical plans, offering services in the hospital, office, or home. Contracts are written on an indemnity basis, but for the low income group the coverage is essentially a service coverage, since there is an unwritten agreement by the participating physicians that for patients who fall into this category the physician's fee should not exceed the benefit allowance. There has been continued fine cooperation in carrying out this understanding.

Under the surgical contract the subscriber is covered for service in hospital, office, or home according to the allowances stipulated in the schedule of benefits, for maternity care after the first year. The medical contract is offered only as a rider to the surgical contract and it provides benefits of $2 per hospital or office call and $3 per home visit. The first two calls in any one illness are excluded from coverage, and the number of calls per year is limited to twenty-five for the subscriber and fifteen for each dependent.

Under either contract the subscriber is entitled to an indemnity of $25 for x-ray examination and $15 for laboratory examination in any one contract year, and under the surgical contract an allowance of $10 is made for anesthesia.

Blue Cross Relations: The Blue Cross organization is the fiscal agent for the New Hampshire

continued on page 946



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"... for the patient to use, between treatments or when it is not convenient to take one, is the Benzedrine Inhaler."

Wier, F.A.: Clin. Med. & Surg. 43:217.

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MEDICAL CARE THROUGH PREPAID INSURANCE

continued from page 944

Physicians Service, the same director serving both corporations. Expenses are prorated in proportion to subscriber income.

Vermont

On October 5, 1945, the Vermont State Medical Society's House of Delegates approved the establishment of a non-profit corporation for prepaid surgical and medical care by the Vermont State Medical Society. On January 13, 1946, the Council of the Society set up a committee to take the necessary steps to put such a plan in operation, and recommended certain principles as the basis for the plan.

On April 11, 1946, the Secretary of State of Vermont issued Articles of Association to the Vermont Physician Service, Inc., a non-profit corporation formed under a pre-existing special enabling act, to offer medical and surgical coverage to the people of this state. The first meeting of the Board of Trustees was held May 6, 1946, and a temporary office was established in the headquarters of the Vermont State Medical Society at Rutland. The contracts, rates, etc., as used by the New Hampshire Physician Service were approved.

On June 8, 1946, negotiations were instituted with the New Hampshire-Vermont Hospitalization Service (Blue Cross) for the coordination of the activities of the two organizations. At the special session of the Vermont Legislature late in September, passage of an amendment to the enabling act was procured, so that the New Hampshire Physician Service could operate in Vermont. As a result of this legislation, it is now planned that the New Hampshire Physician Service will change its name to New Hampshire-Vermont Physician Service and proceed to qualify with the Vermont Commissioner of Banking and Insurance. The Vermont State Medical Society will secure representation on the Board of Directors of this organization, and the enrollment and administration will be done under contract by the New Hampshire-Vermont Hospitalization Service. The practical effect is a merger of the Vermont Physician Service, Inc., with the New Hampshire Physician Service.

Inasmuch as the New Hampshire-Vermont Hospitalization Service (Blue Cross) is already engaged in issuing contracts for hospitalization in Vermont, it is expected that there will be practically no delay in issuing surgical and medical contracts, once the necessary formalities are completed.

Rhode Island

Enabling legislation to permit the forming of a non-profit medical service corporation was passed by the Rhode Island General Assembly. The act provides among other things that no articles of association for a non-profit medical service corporation shall be filed in the office of the Secretary of State unless and until the Governor of this State shall have certified in writing upon such articles that he has determined the public convenience and advantage will be promoted by the establishment of such corporation and that the filing of such articles has the approval of the Rhode Island Medical Society as evidenced by an affidavit of the president and secretary of such society.

A study committee elected by the House of Delegates of the society selected five representative citizens to assist it in its work. The findings of this group urging close cooperation with the Blue Cross in order that the common efforts of the two organizations might not be duplicated, were accepted by the House of Delegates. Subsequently the society authorized its president and its secretary to file an affidavit with the Secretary of State giving permission to Blue Cross to amend its articles of incorporation so that it might be a medical service corporation.

Under this arrangement, permitted by the enabling act, Blue Cross would add a surgical rider to its hospitalization contract, and one corporation would administer both plans. To provide larger medical representation on the board of directors of the Corporation an agreement was made that one of every four directors shall be a doctor of medicine elected by the Rhode Island Medical Society. Provision was also made by agreement that the schedule of indemnity benefits, and any changes to it, shall remain always under the jurisdiction of the medical society.

A steering committee composed of representatives of Blue Cross and the Medical Society worked out details for the surgical program calling for services in and out of the hospital. A schedule of indemnity benefits (the plan would be a service plan for those within an annual $2,500 income, and above that amount an indemnity plan) was drafted, accepted by the society and the Blue Cross. The subscriber contract and physician agreement were drafted by Blue Cross.

However, in its surgical rider Blue Cross included wording that indicated that osteopathic physicians would be accepted by it as participating physicians. This development has prevented the inauguration of the program this fall, as the Medical Society has ruled, through its House of Delegates, that it considers the plan it has drawn jointly with the Blue Cross to be one that should be restricted, as regards participating and non-participating physicians, to doctors of medicine licensed by the state board of medical examiners. The

continued on page 948



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MEDICAL CARE THROUGH PREPAID INSURANCE

continued from page 946

requirement has not as yet been accepted by the board of directors of the Blue Cross who are trying to effect some compromise.

If this difficulty is cleared the surgical plan in Rhode Island could be initiated in the immediate future, as all other preliminary details, other than the signing of participating physicians, have been completed.

Connecticut

The State Medical Society has had committees surveying this subject since 1938 and a number of productive steps have been taken.

The first definite action after long study was a resolution by the House of Delegates of the Society that the Committee on Prepaid Medical Service proceed with the development of a cash indemnity plan to be operated by a corporate insurance company. Progress was being made in this direction when the agent for the company concerned became acutely and seriously ill and his recovery uncertain (he has since recovered fortunately).

Next, the Society's Committee proceeded with the organization of Connecticut Medical Service as is permitted by legislation in this State. The organization was not actually incorporated but had already filed papers of incorporation pending certain other developments.

Connecticut Medical Service then entered into negotiations with Connecticut Hospital Service (Blue Cross) seeking the cooperation of Connecticut Hospital Service as the seller and administrative agent for a cash indemnity prepaid medical service, the contract for which had been prepared. The medical service was to be underwritten by a separate non-profit corporation with its own board of directors and capital structure.

Negotiations between Connecticut Medical Service and Connecticut Hospital Service went on for many weeks and finally (about three or four weeks ago) Connecticut Hospital Service informed us that it was not interested in cooperating with Connecticut Medical Service (the Medical Society's Medical Service Plan) in the promotion and administration of a cash indemnity plan.

We are back now reopening negotiations with corporate insurance carriers.

Maine

The question of prepaid medical care in Maine is still far from being settled in spite of hard work and conscientious thinking by more than one committee. Two years ago when the idea of a plan was initiated the Blue Cross refused to write a plan for the Maine Medical Association as a unit, and it insisted on including osteopathic organizaton. As a result the House of Delegates voted not to adopt such a program then.

Within the past year a committee was appointed by the Council to renew the study. In the committee's report to the House of Delegates last June reference is made to three meetings which proved unsuccessful in working out an arrangement with the Blue Cross. As a result the Council recommended to the House of Delegates at the annual meeting in June that the study of prepaid voluntary medical care insurance be continued by another committee to be appointed by the President. It was suggested that such a committee be authorized to take any steps necessary to secure an enabling act which would empower the Maine Medical Association to adopt a representative insurance plan when such can be formulated.

Summary

Enabling legislation to permit the formation of non-profit prepaid voluntary medical-surgical insurance plans has been enacted in each of the New England States except Maine.

Two states — Massachusetts and New Hampshire — already have successful programs in operation. One, Vermont, is soon to offer contracts similar to New Hampshire Physicians Service as the result of an affiliation with that organization similar to the two-state hospitalization service plan.

Two states — Connecticut and Rhode Island — have completed the preliminary details relative to their plans, but have been balked in the inauguration of the service by inability to secure Blue Cross cooperation.

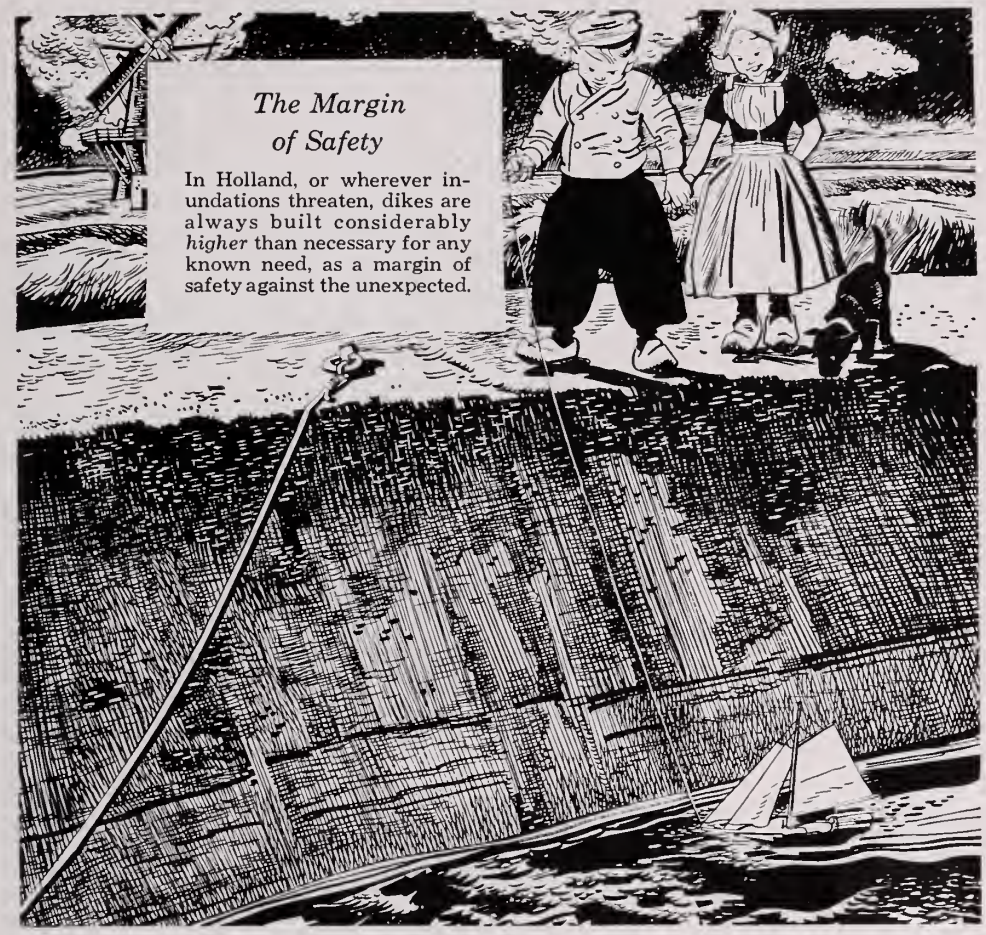
Comment

The potential development of medical-surgical care plans in New England, on the basis of present planning, would offer one of the most interesting studies in the country of this type of insurance. This statement is made in view of the variety of the plans in operation or proposed. For example —

Administration: Three would have Blue Cross as the business organization to merchandise the contract, and would have separate corporations for the medical and the hospital plans. One would have the Blue Cross as the medical service corporation, with one board of directors administering both programs. One, and possibly two, would consider having private commercial insurance companies merchandise the service under approval of the medical society.

Services: Pending disclosure of the details of the plans in process of development it would appear that the services would range from those only in the hospital, to those in hospital, office and home; that surgical care in some instances would be only for hospitalized subscribers, and in others for any services in any location; that only surgical services

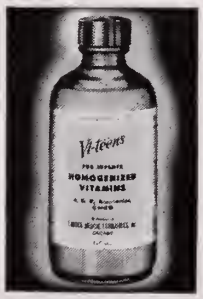
continued on page 950



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Vitamin B_1	1 Milligram
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Vitamin C	40 Milligrams
Vitamin D	800 U.S.P. Units
Niacinamide	4 Milligrams



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MEDICAL CARE THROUGH PREPAID INSURANCE

concluded from page 948

would be offered, and that both surgical and medical services would be possible.

Conflicts: Licensure regulations offer another interesting and serious study. In Massachusetts osteopathic physicians can be participating physicians. In New Hampshire, and presumably in the Vermont plan also, they would be paid as non-participating physicians. Rhode Island and Maine will not consider a plan that includes osteopaths.

While it would appear that these varied problems may hinder to some extent the development of the various plans, yet there is reason to feel that the presence of such difficulties will do much to strengthen the entire framework of medical service through insurance programs. The possibility of a successful national contract will depend in great measure upon the general agreement on fundamental principles involved. That New England offers a variety of thinking in its planning is commendable at this stage when every effort should be directed towards a clarification of issues that may be future obstacles to the progress of the extension of medical care.

Possibly the Council of the New England State Medical Societies may be one vehicle by which the thinking throughout the area may be crystallized somewhat to pave the way for the inter-state exchange of services for the benefit of the people in this compact section of the nation.

Committee on Medical Care and Prepaid Insurance of the Council of the New England State Medical Societies.

ARTHUR H. RUGGLES, M.D.
MORGAN CUTTS, M.D.
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(Submitted at a meeting of the Council, at Boston, October 29, 1946)

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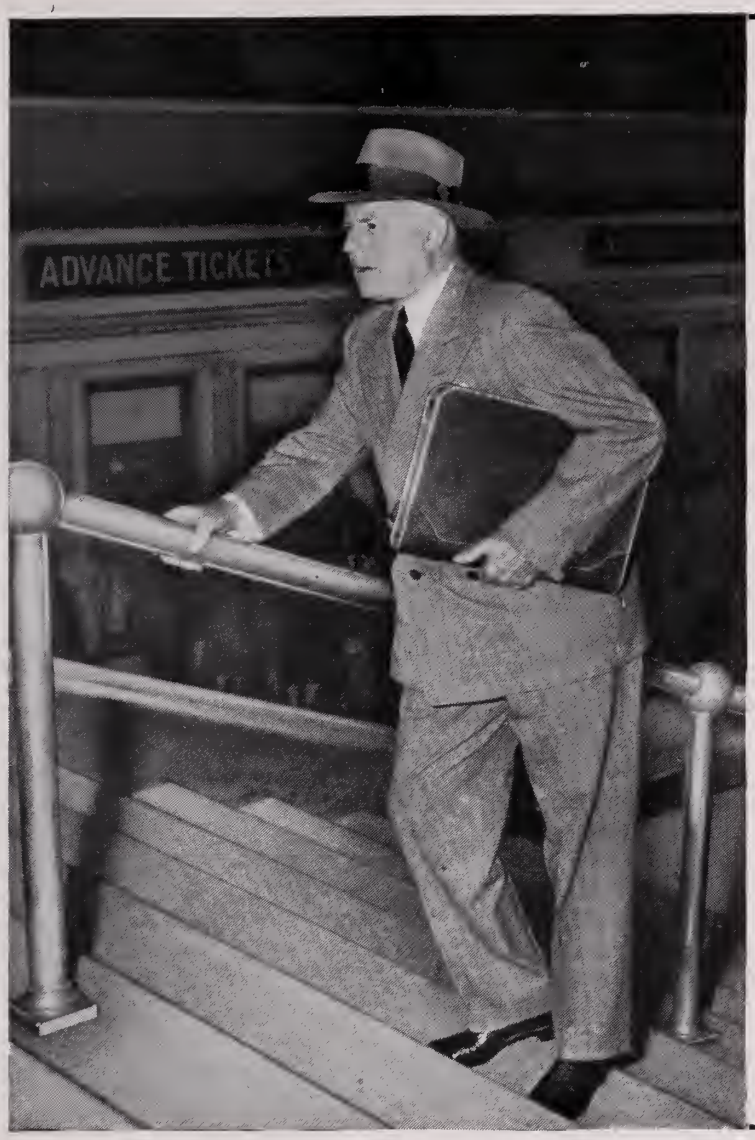
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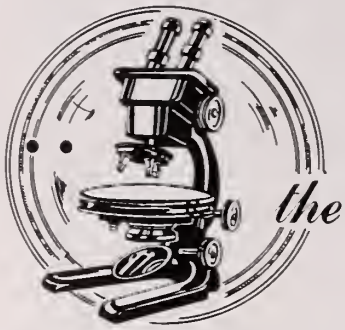
It is generally agreed that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of nitrites. For prophylactic purposes—to control anticipated paroxysms—the delayed but prolonged action *of erythrol tetranitrate is effective. Erythrol tetranitrate, because of its slower* and more prolonged *action, is also considered preferable for the purpose of preventing nocturnal attacks.*

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Coal

THE threatened coal strike again focuses attention upon the question of the coal miners' Health and Welfare Fund which was established last year as one of the compromising features of the strike called by John L. Lewis.

The present agreement between the United Mine Workers and the government provides for two funds. One, a Welfare and Retirement Fund, created by a five per cent per ton impost on every ton of coal produced, will be administered by three trustees, one appointed by the coal administrator, one by the union, and one to be agreed upon by the coal administrator and John L. Lewis. The second fund is a Medical and Hospital Fund which will be built up by a checkoff from the miners' pay and wil be administered by three trustees appointed by the president of the United Mine Workers.

Aside from the implications of these medical funds there are the results of the study that is due to be made known in the coming weeks by the Coal Mine Administration. From this distance we would guess that two features that will be revealed as the result of the study: One will be the great lack of safety devices in the mines (which may be used as an attack against the management of the industry) and the second is the possible indictment of the medical profession in the area of the mining districts for failure to take leadership in providing better or wider distribution of medical services to the miners. Just what will be the reaction when this report is made known is hard to tell, but it is a safe bet that medicine will have to convince its supporters that it can do a better job in providing better medical and hospital services for the miners if it has any hope to sell its own voluntary schemes rather than leave the control of the health and welfare programs to the organized labor groups.

Education

A new technique in health education which will utilize especially prepared films for supplementing a popular textbook used in college freshman hygiene courses and adult education groups was recently announced by a New York publishing company. Marking its entry into the educational film field this company has started production of a series of seven 16 mm sound motion pictures and a like number of coordinated silent film strips on vital health subjects.

* * * * *

The war-created void in scientific manpower which will take five years or longer to make up the shortage of scientists needed has prompted Dr. Thomas Parran, surgeon general of U. S. Public Health Service, to establish approximately 120 one-year fellowships in medical research that are opened to men and women who are graduate science students. The National Cancer Institute, which operates a division of the National Institute of Health, also has funds to train approximately thirty (30) physicians on the diagnosis and treatment of cancer, according to the surgeon general.

Nursing

Alabama reports progress in the standardization of nursing care on the secondary level as a result of the new law which it has enacted to provide for the examining, licensing and regulating of practical nurses in that state. The resonsibility for the administration of the law is delegated to the Nurses Board of Examiners in Registration and an advisory council composed of representatives of the State Board of Health, the State Medical Association, the State Hospital Association, and the State Association of Licensed Practical Nurses, plus a lay member. In pioneering this new movement Alabama has held two-day institutes on practical nursing in the larger cities of the state, and at the present time it has a committee studying standards and policies for the accreditation of schools for practical nurses.

continued on page 954

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THROUGH THE MICROSCOPE

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General Practitioners

With the action of the American Medical Association in establishing a section on the general practice of medicine resulting in subsequent action by the various state medical societies for sections on general practice for their annual meetings, it appears that the swing is towards general medicine, at least for the time being, and away from the intense publicity given to the specialty boards in recent months.

Dr. Orwood Campbell, president of the Hennipen County Medical Society (Minneapolis), remarked significantly in his presidential address recently that in his opinion the general practitioners should have called themselves "The Academy of Family Physicians." Dr. Campbell points that the family is where the general practitioner's real strength lies, as it is there that he can go for support if his existence is ever threatened. In every other respect, according to the doctor, the general practitioner in competition with the specialist is at a disadvantage.

According to Dr. Ray Elledge, president of the Lake County (Indiana) Medical Society, the "general practitioner should fortify his basic training as the years go by. A license to practice medicine should not entitle anyone to ply his profession for life without taking some postgraduate work. The state license should be issued for one year and reissued only on evidence of satisfactory additional training. By so doing, the quality and dignity of general practice would be enhanced and there would be less need for a great number of specialists."

Social Security

The Los Angeles County Medical Association probably has one of the best social security programs for its members that there is in the country for any medical organization. A group of farsighted members of the Society have worked and planned for several years to establish this security through a Physicians' Aid Association. With some 4,000 members in the Association the committee recently reported that approximately one-fourth had contributed to the permanent fund which now totals $193,000.

The directors of the Physicians' Aid Association have set a goal of $500,000 as their minimum total. This money will be used eventually to build a home for destitute practitioners and their dependents, or to establish a fund from which cash relief can be given, or both. None of the fund is now being expended, but with sixty-one persons, including thirty-five physicians, receiving assistance in various ways from the Association it appears that a home will be an outstanding achievement for the Association to establish.

continued on page 956

One-injection control of diabetes



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Most mild and many moderately severe cases may be controlled by *one daily injection of 'Wellcome' Globin Insulin with Zinc*, a clear solution comparable to regular insulin in its freedom from allergenic properties. Vials of 10 cc.; 40 and 80 units per cc. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Pat. 2,161,198. Literature on request.

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PATHOLOGICAL INSTITUTE AND THE COST OF MEDICAL CARE

concluded from page 933

in the community could be assessed a small amount by his medical society or a committee or some group for this purpose, an arrangement could be made with one of the branch members of the pathological institute, in other words, one of the local hospitals, to accept a yearly amount agreed upon and in turn arrange to do all this so-called office laboratory diagnostic work. The physician in turn should be allowed to charge the patient a small blanket fee so that he or she would not feel that they were becoming charity patients. Many of the state laboratories arrange to do all the tests that a physician may send to it, but, there is no place in so far as I know where this so-called out-patient laboratory service will be taken care of other than the commercial laboratories. To repeat, we all know a large percentage of ills can be taken care of outside of the hospitals, but medicine has advanced so rapidly that each physician must have laboratory aid in a large percentage of his cases. All the plans so far such as Blue Cross, Surgical or Medical Plans, take care of the patient after the patient has been admitted to the hospital and all of these various tests are covered at that time.

Finally, this is not advanced as a panacea but I feel that it opens up a field for further study that should be made along these lines.

THROUGH THE MICROSCOPE

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Legislation

Legislation that must be considered in Rhode Island when the assembly meets in January will be the Health Code which was not brought out of committee in the Senate last year because of the fact that the measure was loosely-drawn. Efforts to affect compromises at meetings during the summer have not been reported as yet. Undoubtedly the legislation must receive very careful consideration by the medical profession and all others interested in health problems in the state if it is to satisfy the Assembly. . . . In New York State the secretaries and legislative representatives of the county medical societies met recently in Albany where they learned that a chiropractic licensure bill similar to that offered unsuccessfully at the last session of the state legislature would probably be introduced and pressed at the1947 session. It is also predicted that a new bill to ban the use of live dogs in medical research will make its reappearance.

Dentists

From the prewar average number of dental graduates of 1700 per year, the Council on Dental Education of the American Dental Association recently reported that the dental schools in this country graduated 2600 new dentists during the 1945-1946

continued on page 968



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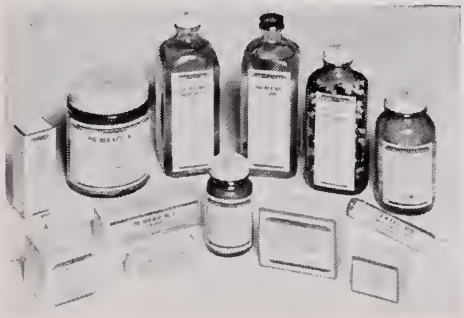
24-hour cultures. *Left*—Sterile water in cup; *Right*—Phe-Mer-Nite in cup. Phe-Mer-Nite dilutions of 1:125,000 to 1:1,000,000 inhibit the growth of streptococci, staphylococci, B. coli, B. typhosus, etc. Dilutions of 1:12,500 to 1:37,500 destroy spore-formers such as B. welchii, B. tetani, and B. chauvei.

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EMIC PROGRAM REACHES MILLION MARK

Somewhere in the United States, on or about Armistice Day, the millionth baby under the Emergency Maternity and Infant Care program was expected to arrive. So figured the Children's Bureau, of the Social Security Administration, Federal Security Agency, which keeps a count of this large lot of servicemen's babies for whom Uncle Sam pays the stork bill. That bill now amounts to almost $100,000,000.

The Emergency Maternity and Infant Care program, which is now in its fourth year of operation, is administered by State health departments under plans approved by the U. S. Children's Bureau. It is in operation in all the States, the District of Columbia, and Alaska, Hawaii, and Puerto Rico.

Wives and infants under 1 year of men in the four lowest pay grades of the Army, Navy, Coast Guard and Marine Corps are eligible under the program without regard to race or to family circumstances. Care is given even after the serviceman's discharge if the pregnancy occurred, or the infant was under one year of age, while the husband and father was in one of the eligible grades.

In addition to the babies already born under this program, another 100,000 are on their way, the Children's Bureau reported. Maternity care is being given to their mothers. Besides, more than 180,000 of the babies already born have received or are receiving additional medical, hospital, or nursing care during their first year of life.

This care is now costing Uncle Sam about $100 for a maternity case and about $65 for an infant's case. In a few cases with complications, the bill runs to well over $1,000. The amount paid covers the cost of good maternity care, including prenatal care, delivery, and care for six weeks after the baby's birth. Doctor, hospital, and nurses' bills are all paid, including those for consultation and laboratory services at rates established under each State plan. Similarly, the medical and hospital bills are paid for the care of a sick baby.

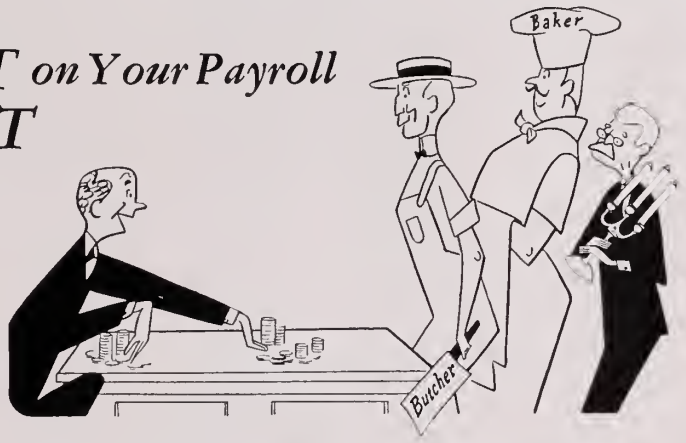
At one time Uncle Sam was paying the stork bill for one out of every seven babies born in the United States. Between 40,000 and 45,000 maternity and infant cases were being authorized a month. Now the total of authorization averages about 15,000 a month.

* * * * *

Estimated Number of Births under the EMIC Program from Beginning of program to November 11, 1946, for the New England States.

State Rank in No. of Births Under Program		*Estimate to November 11, 1946*	*Date of Approval of State Plan*
11	Massachusetts	27,400	August, 1943
32	Connecticut	11,100	May, 1943
38	Maine	6,500	May, 1943
41	Rhode Island	5,200	April, 1943
45	New Hampshire	3,500	June, 1943
47	Vermont	2,800	April, 1943
	Estimated total	56,500	

Put Yourself FIRST on Your Payroll instead of LAST



How to Have Income for the Rest of Your Life

When you sit down to take care of your monthly bills, the butcher, the baker, the candlestick maker, each gets what's coming to him — but are you equally careful about setting aside something for yourself and your family?

Too many of us devote our income to meeting present and past expenses, and save only if there's something left over.

But why put yourself last on the list? Make a definite program for the future a regular part of your budget.

Read about The Connecticut Mutual's Retirement Income plan which enables you to enjoy real peace of mind. Let us send you a copy of our booklet, "What Is the Retirement Income Plan?"

The Connecticut Mutual Life Insurance Company

Walter K. R. Holm, Jr., *General Agent and Associates*

Suite 1814, Industrial Trust Building, Providence 3, Rhode Island

The only vasoconstrictor-sulfonamide which contains Micraform

Micraform sulfathiazole crystals are extremely minute—approximately 1/1000 the mass of ordinary crystals.

Because Paredrine-Sulfathiazole Suspension contains these minute Micraform crystals, it does not cake or clump, and does not inhibit normal ciliary action. (See the clinical drawings on the opposite page.)

Moreover, when ciliary action is impaired by infection, the Suspension's Micraform sulfathiazole spreads in a fine, even film over the affected mucosa, where it establishes bacteriostasis which often lasts for hours.

Rhinitis . . . Sinusitis . . . Nasopharyngitis . . . Pharyngitis

Paredrine-Sulfathiazole Suspension

Vasoconstriction in minutes . . . Bacteriostasis for hours

No ciliary inhibition . . .

No caking . . . No clumping

sulfathiazole



● Five minutes after instillation of Paredrine-Sulfathiazole Suspension in a convalescent nose, the cilia are already forming streams of Micraform sulfathiazole.



● 35 minutes later, the cilia have swept almost all the sulfathiazole away. There is no caking or clumping on *ciliated* epithelium. A few crystals, dried by inspired air, still adhere to the *non-ciliated* anterior borders of the turbinates and to the vibrissae.

Smith, Kline & French Laboratories

Philadelphia, Pa.

MEDICAL LIBRARY NEWS

NEW BOOKS

The Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:

DAVENPORT COLLECTION

John F. Fulton—*Harvey Cushing.* A biography. Springfield, 1946.

Mary S. Gardner—*Katharine Kent.* N. Y., 1946.

Mary L. McDonough — *Poet Physicians.* Springfield, 1945.

Jane M. Oppenheimer—*New Aspects of John and William Hunter.* N. Y., 1946.

ALLERGY

Erich Urbach & Philip M. Gottlieb—*Allergy.* 2nd ed. N. Y., 1946.

BLOOD TRANSFUSION

American Red Cross Blood Donor Service during World War II. Its Organization and Operation. Wash., 1946.

MEDICINE, history

Douglas Guthrie—*A History of Medicine.* Phil., 1946.

MYCOLOGY

Norman F. Conant & others—*Manual of Clinical Mycology.* Phil., 1944.

PHARMACY

Council on Pharmacy and Chemistry, A.M.A.—*New and Non-official Remedies, 1946.* Chic., 1946.

Reports for 1945. Chic., 1946.

TROPICAL MEDICINE

Thomas T. Mackie & others—*Manual of Tropical Medicine.* Phil., 1945.

GIFTS of journals, pamphlets and books from Doctors Harlan P. Abbott, Helen C. Putnam, and Joseph Smith and from the Mead Johnson Company.

WYETH PRESENTS PAINTINGS

The Board of Trustees acknowledges with appreciation the gift from the Wyeth & Company of Philadelphia of five framed reproductions of paintings well-known to physicians. These reproductions have been hung in the Library dining room where they may be viewed by members of the Society. The group paintings by Dean Cornwell consists of the following: "The Father of American Pharmacy—William Proctor, Jr., 1817-1872"; "Beaumont and St. Martin"; "That Mothers Might Live", Oliver Wendell Holmes, 1809-1894; "The Dawn of Abdominal Surgery"; and "Osler at Old Blockley."

* * * * *

The Mead Johnson Company will again run its art exhibition at the AMA meeting at Atlantic City. Cups and medals are the rewards, and also $34,000 in savings bonds for the special contest, "Courage and Devotion Beyond the Call of Duty" (in war and in peace). For complete information write the sponsor, Mead Johnson & Company, Evansville 21, Indiana.

CHARLES F. GORMLY COLLECTION

Seven books have been purchased with money from the Charles F. Gormly Fund. This is the beginning of a collection of texts on medico-legal and allied subjects in memory of Doctor Gormly.

David Abrahamsen—*Crime and the human mind.* N. Y., 1944.

John Glaister—*Medical Jurisprudence and Toxicology.* 8th ed. Edin., 1945.

Alice Hamilton & Rutherford T. Johnstone —*Industrial Toxicology.* N. Y., 1945.

Emanuel Hayt & Lillian R. Hayt—*Legal Guide for American Hospitals.* N. Y., 1940.

Samuel B. Horovitz — *Injury and Death under Workmen's Compensation Laws.* Bost., 1944.

Earl D. McBride—*Disability Evaluation.* 3rd ed. Phil., 1942.

William D. McNally—*Medical Jurisprudence and Toxicology.* Phil., 1939.

New . . . ORAL AMINO ACIDS

AMIPROTE contains all amino acids from 4 of the most important proteins of high biologic value, for *more complete* therapy. High nitrogen content, small bulk; a practical and efficient means of raising protein intake. Exceptional palatability encourages sustained patient cooperation.

Exceptionally Palatable

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PROTEIN HYDROLYSATE COMPOUND

AMIPROTE is an enzyme digest of four excellent nutritional proteins: Beef, Casein, Lactalbumin, and Yeast . . . providing:

PROTEIN HYDROLYSATES (70% Amino Acids and Peptides) 65%

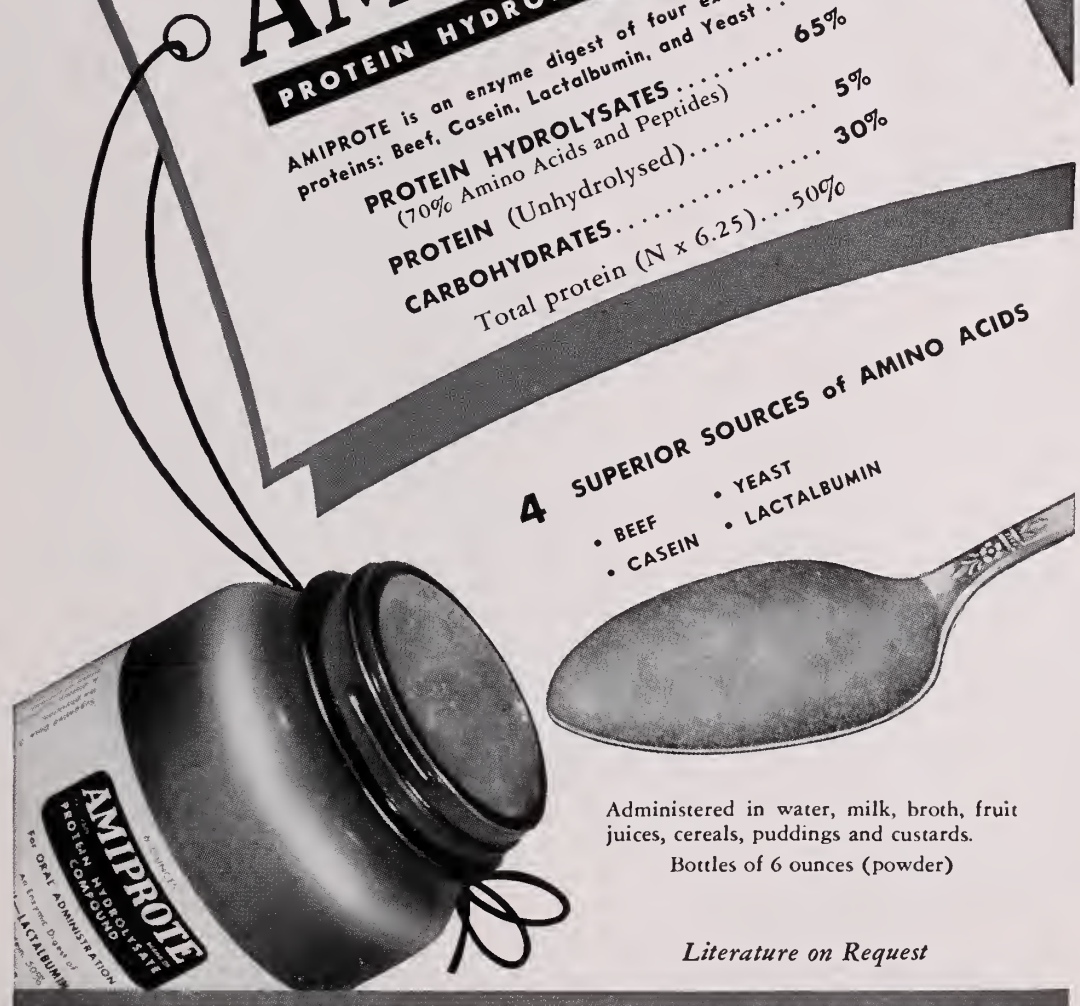
PROTEIN (Unhydrolysed) 5%

CARBOHYDRATES 30%

Total protein (N x 6.25) . . . 50%

4 SUPERIOR SOURCES of AMINO ACIDS

- BEEF
- CASEIN
- YEAST
- LACTALBUMIN



Administered in water, milk, broth, fruit juices, cereals, puddings and custards.

Bottles of 6 ounces (powder)

Literature on Request

U. S. VITAMIN CORPORATION • 250 East 43rd Street, New York 17, N. Y.

NEW ENGLAND'S SCORE CARD IN THE NATIONAL ECONOMY

Prepared by the NEW ENGLAND COUNCIL

In our concern for the economic progress and welfare of New England, it is important to know how our region stands in comparison with the United States as a whole. This is clearly shown in the tables below with respect to numerous important factors in our economy. For example, the population density of New England is 134 per square mile, while for all the United States it is but 44. The proportion of industrial employment in the United States is 23%, in New England it is 38%. These are accurate measures of the extent to which New England is more densely populated and more highly industrialized than the country as a whole. To emphasize New England's relative position the New England figures that are higher than the national figures are printed in bold-faced type.

AREA

66,608 Square Miles
N. E. 2.2% U. S. Total

	NE	US
Total area, percent in lakes and streams	**5.1%**	1.5%
Land area, percent in forest and woodland	**74%**	33%
Land area, percent in farms	33%	56%
Farm land, percent available for crops	39%	50%

PEOPLE

Population 1940 8,437,290
N. E. 6.4% U. S. Total

	NE	US
Population, number of people per square mile	**134**	44
Population, percent living in urban areas	**76%**	57%
Population, percent living in rural areas	24%	44%
Population, percent foreign born white	**18%**	8.7%
Population, percent under 5 years of age	6.8%	8.0%
Population, percent over 65 years of age	**8.5%**	6.9%
Births per thousand persons	16	18
Deaths per thousand persons	**12**	11
Marriages per thousand persons	11	12
Divorces per thousand persons	1.2%	2.0%

EMPLOYMENT

Total Number Employed 3,231,235
N. E. 6.8% U. S. Total

	NE	US
Population, percent of total number employed	**38%**	36%
Percent of total employment accounted for by:		
Manufacturing	**38%**	23%
Agriculture	4.6%	19%
Forestry, fishing and mining	0.5%	2.2%
Wholesale and retail trade	17%	17%
Construction	**4.6%**	4.5%
Transportation, communication, utilities	5.9%	6.9%
Finance, services, etc.	**29%**	28%

MANUFACTURING

Value of Products $4,891,666
N. E. 8.6% U. S. Total

	NE	US
All manufactured products, value per capita	**$580**	$432
Foods products, value per capita	$ 51	$ 81
Textile and fiber products, value per capita	**$126**	$ 30
Apparel and fabric products, value per capita	**$ 26**	$ 25
Wood and wood products, value per capita	$ 15	$ 18
Paper prod., publishing, printing, value per capita	**$ 60**	$ 35
Chemicals and allied products, value per capita	$ 22	$ 28
Rubber products, value per capita	**$ 14**	$ 7
Leather and leather products, value per capita	**$ 51**	$ 11
Stone, clay and glass products, value per capita	$ 9	$ 11
Iron and steel products, value per capita	$ 44	$ 50
Nonferrous metal products, value per capita	**$ 40**	$ 20
Electrical equipment, value per capita	**$ 30**	$ 13
Machinery, value per capita	**$ 43**	$ 25
Automobiles and equipment, value per capita	$ 3	$ 31
Other transportation equipment, value per capita	**$ 16**	$ 6
Other products, value per capita	$ 29	$ 41
Value of manufactured products per wage earner	$5130	$7207
Value added by manufacture, per wage earner	$2546	$3130
Plants, less than 5 employees, % of total	40%	46%
Plants, over 500 employees, % of total	**2.0%**	1.2%

AGRICULTURE

Value of Products $236,200,000
N. E. 3.0% U. S. Total

	NE	US
Agricultural products, value per capita	$ 28	$ 59
Average acreage per farm	99	174
Average value per acre, land and buildings	**$ 55**	$ 32

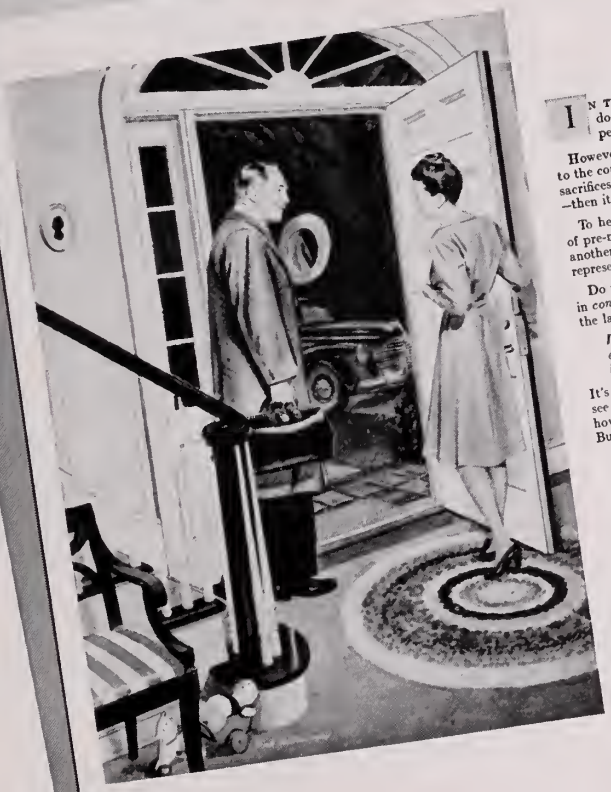
continued on page 966

SUBJECT: "YOUR DOCTOR"
AUDIENCE: 23 MILLION PEOPLE

This is the 200th message published by Parke, Davis & Company in the interest of the medical profession. It appears this month in full color in LIFE and other leading national magazines.

Some things you should know about your doctor

No. 200 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



IN TIMES of distress, almost everyone turns to his doctor. But when things are going smoothly, some people are apt to take him pretty much for granted.

However, if you consider your doctor's service to you and to the country—if you consider the skills he must have, the sacrifices he must make, the hardships he must work under—then it isn't very easy to take him for granted.

To become a doctor usually requires three to four years of pre-medical education, four years of medical school, and another year or more as an interne. But this by no means represents the end of his training.

Do you realize how much time your doctor has to spend in *continuing* study—so he can bring you the benefits of all the latest medical advances?

During a year the average American doctor devotes the equivalent of about a month to the study of medical books and journals and to attending medical meetings.

It's an old story about how many patients a doctor has to see every day, how much of his time he devotes to charity, how many calls he has to make in the middle of the night. But did you ever think of it this way:

When you leave your office or job, the chances are that you're free from business duties for another day. You can do whatever you feel like—you can dig in your garden, visit friends, have a quiet evening at home with your family, drop in at a movie, or go for a drive. But your doctor's work is never finished. He's always—every waking and sleeping moment—responsible for the patients under his care.

Yes, it takes a lot of things to be a good doctor. It takes physical and nervous stamina. It takes patience. It takes great tact. It takes an understanding of people. It takes sound judgment. It takes unusual scientific and scholastic aptitude. It takes a sympathy for the unfortunate. Above all, it takes a spirit of humanitarianism and a sense of service.

Tall order, isn't it? Yet thousands and thousands of American physicians have all these qualities—and more. They are outstanding men and women. America should never cease to be proud of them.

Makers of medicines prescribed by physicians

PARKE, DAVIS & CO.

Research and Manufacturing Laboratories • Detroit 32, Michigan

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N. E. SCORE CARD IN THE NATIONAL ECONOMY

concluded from page 964

Average tax per acre (Owner-operated farms)	**$ 1.13**	$ 0.52
Owner-operated farms, percent of total number	**91%**	61%
Farm production, gallons of milk per cow	**610**	525
Farm production, eggs per laying hen	**182**	142
Farm production, potatoes per acre (bushels)	**229**	132

FORESTRY, MINING AND FISHING

	NE	US
Lumber produced (board feet) per capita	72	220
Wood pulp produced (pounds) per capita	**308**	134
Mineral products, value per capita	$2.95	$35
Fisheries products, value per capita	**$2.43**	$ 0.67

SERVICE INDUSTRIES

Trade, Construction, Transportation, Utilities

	NE	US
Wholesale sales per capita	$376	$420
Retail sales per capita	**$393**	$319
Postal receipts per capita	**$ 6.40**	$ 5.51
Service establishment receipts per capita	**$ 28**	$ 26
Construction contracts, value per capita	**$ 38**	$ 30
Railroad mileage per 1000 square miles	**100**	77
Airports per 1000 square miles	**15**	8
Rural highways, percent surfaced	**58%**	41%
Telephones per 1000 persons	**183**	139
Power production, KWH per capita	1063	1101

FINANCE AND TAXATION

	NE	US
Income payments to individuals 1940	**$725**	$575
Income payments to individuals 1945	**$1288**	$1150
Bank deposits per capita	**$835**	$537
Savings deposits per capita	**$527**	$196
Life insurance in force per capita	**$1107**	$877
Individual income tax, average per return	**$123**	$118
State revenue per capita	**$ 42**	$ 39
State expenditures per capita	**$ 38**	$ 35

EDUCATION

	NE	US
Children, percent in public schools	67%	73%
Children, percent in private schools	**16%**	7.5%
Number of school children per teacher	**29**	28
School expenditures per capita of enrollment	**$103**	$ 92
Average salary of public school teachers	**$1748**	$1441
College plants, average value ($000)	**$2077**	$1612
College endowments, average value ($000)	**$3217**	$987

HOUSING

	NE	US
Dwelling units, percent in urban areas	**72%**	58%
Dwelling units, percent in rural areas	5.4%	19%
Dwelling units, percent held for seasonal use	**5.2%**	2.0%
Dwelling units, percent substandard	**5.7%**	14%
Urban dwelling units, percent owner occupied	35%	38%
Rural-nonfarm units, percent owner occupied	**57%**	52%
Rural-farm units, percent owner occupied	**82%**	53%
Median value, urban and rural-nonfarm units	**$3652**	$2938
Median rent, urban and rural-nonfarm units	**$ 26**	$ 24

IN WOONSOCKET IT'S . . .

Joseph Brown Company

Specializing in Prescriptions and Surgical Fittings

EIGHT REGISTERED PHARMACISTS

188 Main Street Woonsocket, R. I.

"If It's from Brown's, It's All Right"

IN MOUNT PLEASANT IT'S . . .

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Darthronol



presents in a single capsule adequate potencies of the nine vitamins which repeatedly have been reported to play an important role in the management of the arthritic patient.

EACH CAPSULE CONTAINS:

Vitamin D (Irradiated Ergosterol)	50,000 U.S.P. Units
Vitamin A (Fish-Liver Oil)	5,000 U.S.P. Units
Ascorbic Acid	75 mg.
Thiamine Hydrochloride	3 mg.
Riboflavin	2 mg.
Pyridoxine Hydrochloride	0.3 mg.
Calcium Pantothenate	1 mg.
Niacinamide	15 mg.
Mixed Natural Tocopherols	3.4 mg.

(Equivalent in biological activity to 3 mg. of Alpha Tocopherol)

Through the pharmacodynamic and nutritional actions of its nine constituents, Darthronol not only exerts a beneficial influence on the typical involvement of the locomotor structures, but in addition is of value in the control of many systemic disturbances frequently encountered in the arthritic syndrome.

The comprehensive brochure "Systemic Therapy in the Arthritides" is available on request.

J.B. ROERIG & COMPANY • 536 Lake Shore Drive, Chicago 11, Illinois

Continue

The

Battle

Against

TUBERCULOSIS



THROUGH THE MICROSCOPE

continued from page 956

school year, making the second largest in the recent history of the profession and reflecting the accelerated training program adopted by dental colleges during the war years.

Although the number of graduates increased during the war years, enrollments of beginning dental students dropped sharply due to manpower demands of the armed forces. As a result there will be smaller graduating classes during the next two to three years. However, this will be partially offset later when the present freshmen enrollment at the nation's forty dental schools, now in excess of 3,000 students of whom 90 per cent are veterans of World War II, complete their training.

* * * * *

The 1947 full scale scientific meeting of the American Dental Association will be held in Boston next year, the first or second week in August, according to present plans.

Meetings

It is not too early to start planning for your attendance at the centennial meeting of the American Medical Association to be held at Atlantic City June 9-13. Hotel reservations should be made far in advance as undoubtedly this meeting will draw the largest attendance in the history of the Association.

Incidentally, only Fellows and invited guests are eligible to attend the meeting. Membership in your state society is the primary qualification for Fellowship in the AMA. Fellowship dues and subscription to the Journal of the AMA are both included in one annual payment of $8.00 which is the cost of the Journal to subscribers who are not Fellows.

* * * * *

The American Urological Association again offers an annual award, not to exceed $500, for an essay on the result of some clinical or laboratory research in urology. For full particulars write to the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before May 1, 1947.

PATRONIZE

JOURNAL

ADVERTISERS



"Bronchial Asthma ... etiology undefined"

In the paroxysms of bronchial asthma neither the physician nor his patient can wait for full identification of all asthmagens. *Without delay, symptoms must be relieved.*

PARASMA provides this rapid, symptomatic relief by the *oral* route. It is a synergistic combination of three principal oral antiasthmatics recognized individually in the *United States Pharmacopoeia.*

The combined PARASMA formula often succeeds where its components are ineffective singly, yet it does not involve the use of barbiturates, narcotics, pyrazolons or strychnine. On request, you will receive a free, full-size trade package of PARASMA for trial in your practice.

Parasma is not advertised to the Laity

Each PARASMA tablet contains ephedrine hydrochloride 1/8 gr., aminophylline 1 gr. and sodium bromide 3 gr. It is *indicated* in bronchial asthma to prevent or abort paroxysmal attacks and as a sustaining therapy.

PARASMA

DOSAGE: *3 tablets with water. Not to exceed 5 tablets in 3 hours or 10 tablets per day. Intermittent courses of 5 days per week recommended. Caution — too frequent or protracted use may lead to bromism or anxiety symptoms. Contraindicated in cardiac or renal disease, hyperthyroidism, hypertension or diabetes.*

HOW SUPPLIED: *Bottles of 24 tablets.*

for symptomatic relief of bronchial asthma

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Please send literature and a free, full-sized trade package of PARASMA.

☐ I am also interested in colonic constipation therapy. You may include corresponding material on EMODEX.

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BENZESTROL
(?, 4-di (p-hydroxyphenyl) -3-ethyl hexone)

the Preferred Estrogen

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Schieffelin BENZESTROL is rapidly becoming the therapeutic agent of choice where estrogen therapy is indicated. Clinical potency, marked tolerance and economy are the features to recommend its use.

Available in tablets, potencies of 0.5, 0.1, 2.0 and 5.0 mg.; in 10 cc. vials containing 5.0 mg. per cc., and in ellipsoid shaped vaginal tablets of 0.5 mg. strength, the physician has a choice of three modes of administration.

Literature and Sample on Request

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Pharmaceutical and Research Laboratories
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Going away?...

The problem of securing high Quality Milk at seashore and country points is a difficult one.

"PLAY SAFE" . . . PRESCRIBE **Certified Milk** *FOR*

• ***Preparation of Infant Formulas*** • ***Runabouts*** • ***Convalescents***

Delivered fresh daily in the principal shore and country points in New England.

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MILK COMMISSION

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Cherry Hill Farm	H. P. Hood Co.	DE 3024
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Cabbage
Cantaloupe
Carrot
Cauliflower
Celery
Cheese, American
Cheese, Swiss
Cherry
Chicken
Clam, Hard
Cocoa
Cocoanut
Codfish
Coffee
Corn
Crab
Cucumber
Duck
Eggwhite
Eggyolk
Flounder
Gelatin
Ginger
Grape (Raisin)
Grapefruit
Halibut
Herring
Honeydew
Lactalbumin
Lamb
Lettuce
Lima Bean
Lobster
Mackerel
Milk (Cow)
Mushroom
Mustard
Oat
Onion
Orange
Oyster
Pea
Peanut
Pecan
Pepper (Red, Green)
Perch
Pike
Pineapple
Pork
Potato
Prune (Plum)
Pumpkin
Quince Seed
Radish
Rice
Rye
Salmon
Sardine
Scallop
Shrimp
Soy Bean
Spinach
Strawberry
Sweet Potato
Tomato
Tuna Fish
Veal
Walnut (English)
Wheat
Whitefish (Lake)
Yeast

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Orris Root
Pyrethrum
Silk
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Cat Hair
Cattle Hair
Dog Hair
Goat Hair
Feathers, mixed
Hog Hair
Horse Dander
Rabbit Hair
Sheep Wool

FUNGUS ALLERGENS

Alternaria sp.
Aspergillus fumigatus
Chaetomium sp.
Cladosporium
Epidermophyton inguinale
Hormodendron
Monilia sitophila
Mucor plumbeus
Penicillium digitatum
Trichophyton interdigitale

Arlington

THERE is increasing evidence that, in asthma, gastrointestinal allergies, infantile eczema, migraine, etc., treatment of allergic sensitivities is yielding gratifying results.

To facilitate diagnosis, Arlington offers a specially prepared assortment of 112 diagnostic allergens representing the most commonly reported causative factors . . . foods, epidermals, fungi and incidentals. Each vial contains sufficient material for at least 30 tests. Full instructions for the simple scratch-test technique and a supply of N/20 NaOH are included.

These dry allergens remain active indefinitely at room temperature. The allergens listed represent the standard Arlington selection. If preferred you may make your own selection of 112 allergens from our current list, available upon request.

$35.00 ALLERGY DIAGNOSTIC SET

Biological Division

THE ARLINGTON CHEMICAL COMPANY

YONKERS 1 NEW YORK

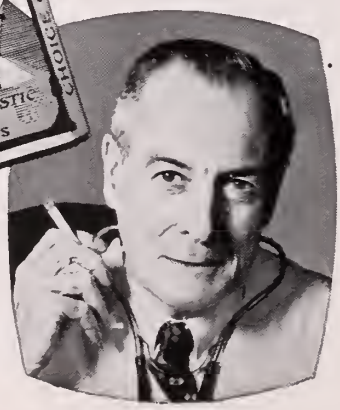


The Doctors behind the Doctor



● Magical penicillin . . . the amazing "sulfas". . . and now the new streptomycin . . . Thank the men of research medicine for those . . . and for all the other valuable aids they have placed in the doctor's "little black bag."

Biochemists and bacteriologists . . . pathologists and physiologists . . . whatever the field of research . . . they are, first and foremost, *doctors!* And, like all doctors, they are tirelessly devoting their lives to the cause of human health and happiness.



R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

According to a recent independent nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette



MINIMIZES GASTROINTESTINAL DISTRESS

Gastrointestinal distress attributable to the presence in the intestinal tract of excessive amounts of readily fermentable sugars can be minimized by specifying CARTOSE* as the mixed carbohydrate to be used in modifying milk for infant feeding formulas.

CARTOSE supplies balanced proportions of nonfermentable dextrins in association with maltose and dextrose, thus providing spaced absorption.

Its content of dextrins favors the development of a preponderant beneficial acidophilic intestinal flora.

CARTOSE
REG. U. S. PAT. OFF.
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